

# **Maternal health care utilisation in urban informal settlements: a grounded theory of manoeuvring**

**Glyn Alcock**

Institute for Global Health

**University College London**

Supervisor : Professor David Osrin

Co-supervisor : Professor Audrey Prost

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## **Declaration**

I, Glyn Alcock, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm this has been indicated in the thesis.

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## **Abstract**

Despite substantial reductions, maternal and newborn mortality in India remain high. Access to maternity care is crucial, but research tends to emphasise uptake, overlooking patterns of utilisation. The urban scenario is complex: public and private health infrastructure is available but poorer groups face substantial inequalities in access. Understanding how families choose health providers and utilise services is essential to address inequalities and improve user experience. In this thesis, I examine the dynamics of maternity care-seeking in Mumbai's informal settlements and develop a substantive grounded theory of health care utilisation.

The study took place in informal communities in eastern Mumbai. Using mixed methods, I described patterns and determinants of maternity care, and used grounded theory to explain women's choice of health care provider and utilisation of services.

Uptake of institutional maternity care was high. Tertiary public hospitals were the commonest source of maternity care, but most women preferred the private sector because of superior quality and experiences. There were inequalities in uptake and utilisation across socio-economic groups. Motivated by an awareness of the potential risks of pregnancy and childbirth and a desire for positive health outcomes, families engaged in a process I called 'manoeuvring', a form of reflexive monitoring involving three interrelated stages: 'exploring the options', involving gathering information about health care options and providers, 'purposive selection', the identification of suitable providers, and 'managing the health care encounter', actions to move through the system, including negotiating with providers and reflecting on care-seeking experiences.

In Mumbai's informal settlements, institutional maternity care is the norm, although substantial inequalities exist. The process of choosing and utilising health care is complex. Manoeuvring explains how women living in challenging social and economic conditions choose and interact with health care services in a continuous process reflexive monitoring. Health managers must ensure quality services, a functioning regulatory mechanism, and monitoring of provider behaviour.

## **Impact statement**

Despite substantial reductions in maternal and newborn mortality in India, rates remain high and are declining at a slower rate than in other similar South Asian countries. Access to maternity care is crucial but the urban scenario is complex: public and private health infrastructure is available but poorer groups face substantial inequalities in access.

The study combines data from a cluster randomised controlled trial baseline census of more than 3000 women living in informal settlements in Mumbai's two least developed municipal wards, with qualitative interviews with 75 pregnant women and mothers. It describes patterns of prenatal and delivery care-seeking and develops a grounded theory to explain them. Using empirical qualitative and quantitative methods, it provides a more comprehensive account of the dynamic care-seeking process in a socio-economically deprived area than studies employing single methods.

The findings of the study provide evidence of persistent maternal health disparities and inequitable access to vital health care services. These reflect a broader pattern common in many low- and middle-income countries. The study describes how perceptions of risk and uncertainty frame decisions to seek health care, and the effect of constraining socio-economic conditions on opportunities to utilise services. In addition, it explains how women in informal settlements perceive their maternal health care needs, choose and access a range of health services, and interact with a complex urban health care system.

The study findings contribute to a growing body of knowledge on health and health-seeking practices in low- and middle-income countries. The qualitative findings point to important factors that play a key role in maternal health care utilisation other than health service provision, such as access to social networks and communication between providers and clients. Therefore, the study is potentially useful to a wide audience including health campaigners, researchers, policy makers, and programme managers, or other organizations interested in understanding, advocating for, and reducing health care inequalities in low- and middle-income countries. In addition, it

could provide a model on which to develop further research into the mechanisms linking socio-economic inequalities and health care-seeking.

The study could help identify specific areas of intervention and potential mechanisms of impact to inform equitable health policy and programmes, or in the design and implementation of community-based health programmes. Designing and implementing well-informed, appropriate health programmes in populations who are most in need can improve participation, and programme effectiveness. This, in turn, has the potential to benefit participants by providing services that are acceptable, equitable, and that lead to greater improvements in health.

Finally, the use of an ambitious mixed method design that combines quantitative data and grounded theory might be of interest to other researchers contemplating developing similar work. The strengths and limitations of the study design should provide some information to guide such projects.

## Table of contents

Abstract .....	3
Impact statement .....	4
Table of contents .....	6
Table of tables .....	13
Table of boxes .....	13
Table of figures .....	14
Acknowledgements .....	15
Chapter 1 Introduction .....	18
1.1 Background to the research .....	18
1.2 Role of the researcher .....	20
1.3 Structure of the thesis .....	21
Chapter 2 Urbanisation and health care inequalities .....	22
Chapter 3 Global and Indian perspectives on maternal health care utilisation .....	27
3.1 Literature search .....	27
3.2 Maternal and perinatal health: global and Indian progress .....	28
3.2.1 Global epidemiology of maternal and perinatal health .....	28
3.2.2 Maternal and perinatal health in India .....	31
3.3 The case for maternity care .....	33
3.4 Global and Indian guidance on maternity care-seeking .....	35
3.4.1 International policy and guidelines .....	35
3.4.2 National policy and guidelines .....	37
3.5 Patterns and determinants of maternal health care utilisation in India .....	39
3.5.1 Variation in choice of provider .....	40
3.5.2 Regional and state variations .....	41
3.5.3 Rural and urban disparities .....	43
3.5.4 Variations in maternal healthcare-seeking <i>within</i> urban areas .....	44

3.5.5	Individual, household, and broader structural determinants of maternal health care-seeking .....	45
Chapter 4	Health-seeking behaviour.....	54
4.1	Understanding health-seeking behaviour .....	54
4.2	Models of health-seeking behaviour .....	55
4.2.1	Social cognitive models .....	57
4.2.2	Sociological models .....	59
4.2.2.1	Suchman: five stages of illness and medical care.....	59
4.2.2.2	Igun: eleven stages of health-seeking .....	62
4.2.2.3	Behavioural model of health care utilisation .....	63
4.2.3	Contributions from medical anthropology .....	65
4.3	Assessing health-seeking behaviour models .....	69
4.4	Social structure and individual agency.....	71
4.4.1	Structure, agency, and health .....	71
4.4.2	Theories of practice.....	74
4.5	Sociological and anthropological studies of maternal health care in India .	79
4.5.1	Constrained care-seeking .....	81
4.5.2	Shifting social norms .....	82
4.5.3	Structure and agency in maternal health decision-making .....	83
4.5.4	Experiences of health care utilisation .....	86
4.5.5	Violence, discrimination, and dissatisfaction .....	86
Chapter 5	Study setting.....	88
5.1	Brief introduction to India.....	89
5.1.1	Health care system .....	90
5.1.2	Maternal health care utilisation.....	92
5.2	Mumbai .....	93
5.2.1	Demography and urban growth.....	94

5.2.2	Governance .....	96
5.2.3	Economy .....	96
5.2.4	Urban poverty and informal settlements .....	97
5.2.5	Social and health indicators .....	99
5.2.6	Maternity care-seeking in Mumbai's informal settlements .....	101
5.3	The SNEHA Centre trial .....	105
Chapter 6	Methods.....	108
6.1	Introduction .....	108
6.2	Aims and objectives .....	108
6.3	Study design .....	108
6.4	Grounded theory .....	112
6.4.1	Overview .....	112
6.4.2	Methods in classic grounded theory.....	115
6.4.2.1	Coding.....	116
6.4.2.2	Writing memos .....	117
6.4.2.3	Theoretical sampling.....	117
6.4.2.4	Selective coding.....	117
6.4.2.5	Sorting and writing .....	118
6.5	Use of the literature .....	118
6.5.1	Quantitative .....	118
6.5.2	Qualitative .....	118
6.6	Evaluating grounded theory .....	120
6.6.1	Ethical considerations .....	121
6.6.1.1	Consent .....	121
6.6.1.2	Ethical approval .....	122
6.7	Data sources and sampling .....	122
6.7.1	Quantitative sampling .....	122



6.7.2	Qualitative sampling .....	123
6.8	Data collection.....	124
6.8.1	Quantitative data .....	124
6.8.2	Qualitative data .....	127
6.9	Data analysis.....	130
6.9.1	Quantitative analysis .....	130
6.9.1.1	Dependent variables.....	130
6.9.1.2	Independent variables .....	131
	Household asset quintile.....	131
	Maternal education .....	132
	Maternal age .....	132
	Parity .....	132
	Duration of residence .....	132
	Religion .....	133
6.9.1.3	Statistical analysis.....	133
6.9.2	Qualitative analysis .....	134
6.9.2.1	Open coding.....	135
6.9.2.2	Developing and integrating categories .....	138
6.9.2.3	Writing memos .....	139
6.9.2.4	Delimiting the theory .....	140
6.10	Reflexivity and research .....	140
Chapter 7	Quantitative results.....	142
Chapter 8	Qualitative findings and the grounded theory .....	150
8.1	Theory overview.....	150
8.2	Conditions in which manoeuvring took place .....	153
8.2.1	Perceptions of risk and uncertainty .....	153
8.2.2	Urban opportunity and choice .....	159

8.3	Exploring the options .....	160
8.3.1	Being informed.....	160
8.3.1.1	Personal knowledge and experience .....	162
8.3.1.2	Seeking information and advice .....	163
8.3.1.3	Visiting a prospective health provider .....	165
8.3.2	Defining a sphere of accessibility .....	166
8.3.2.1	Assessing financial capacity .....	167
8.3.2.2	Internalising status .....	168
8.4	Purposive selection.....	170
8.4.1	Examining the evidence .....	171
8.4.1.1	Forming perceptions of public and private providers.....	173
8.4.2	Defining health care needs and expectations .....	175
8.4.2.1	Positive health outcomes .....	175
8.4.2.2	Appropriateness of care .....	176
8.4.2.3	Convenience.....	176
	Comprehensiveness .....	176
	Affordability .....	177
	Efficiency and efficacy .....	179
	Proximity and timeliness .....	179
8.4.2.4	Positive interaction with health facility staff .....	183
8.4.3	Confronting constraints.....	184
8.4.3.1	Mobilising resources.....	192
8.4.3.2	Adapting to constraints .....	193
	Living within means .....	193
	Managing multiple roles.....	194
	Compromising on care .....	194
8.5	Managing the health care encounter.....	195

8.5.1	Experiencing health care .....	196
8.5.2	Navigating the system .....	200
8.5.2.1	Questioning medical advice.....	202
8.5.2.2	Negotiating medical intervention.....	202
8.5.2.3	Being assertive .....	203
8.5.3	Reconstructing experiences.....	206
8.5.3.1	Defining satisfaction .....	208
Chapter 9	Discussion .....	213
9.1	Patterns and determinants of maternity care .....	215
9.2	Comparison of the theory of manoeuvring with existing models .....	221
9.3	Comparison of the theory with health care-seeking literature.....	227
9.4	Contribution of the study.....	232
Chapter 10	Conclusions .....	234
Chapter 11	Recommendations .....	237
Appendix A.	Published article - Examining inequalities in maternal health care ...	262
Appendix B.	Letter of collaboration with SNEHA .....	273
Appendix C.	Participant information sheet for FGD/interview with women who accessed maternal health care .....	275
Appendix D.	Consent form for FGD/interview with women who accessed maternal health care .....	277
Appendix E.	Selected screenshots of SNEHA Centre baseline census questions ...	279
Appendix F.	Community Resource Centre trial evaluation database design.....	281
Appendix G.	Topic guide for user of institutional maternal health care services....	285
Appendix H.	Topic guide for focus group with women who delivered at home.....	288
Appendix I.	Data collection activities .....	289
Appendix J.	List of participants and selected characteristics.....	291
Appendix K.	Example of a lower quality interview transcript .....	295
Appendix L.	Example of a higher quality transcript.....	320

Appendix M. Example of an early codebook.....	339
Appendix N (i). Example of initial theoretical memo.....	343
Appendix N (ii). Example more developed theoretical memo .....	344
Appendix O. Example conceptual diagram – purposive selection .....	345

## **Table of tables**

Table 1. Definitions used in the thesis .....	16
Table 2. Uptake of institutional prenatal and delivery care in India, by geographical region, and rates in highest and lowest performing states .....	42
Table 3. Format for allocating unique codes to qualitative data .....	129
Table 4. Characteristics of 3848 women respondents in 40 informal settlement areas in Mumbai who had delivered in the two years preceding the census.....	142
Table 5. Prenatal care site, by maternal characteristics, for 3819 deliveries in the two years preceding the census .....	144
Table 6. Odds ratios for uptake of prenatal care and institutional delivery, care in the public sector, and care at tertiary public hospitals, in the two years preceding the study, by maternal characteristics. ....	148

## **Table of boxes**

Box 1. Medical Subject Headings (MeSH) and open search terms used in the literature review .....	28
Box 2. Excerpt from fieldnotes reflecting on a semi-structured interview .....	130
Box 3. Excerpt from a focus group discussion with pregnant women.....	136

## Table of figures

Figure 2.1. Coverage (%) of skilled birth attendance in urban and rural areas for selected regions .....	23
Figure 2.2. Coverage (%) of urban skilled birth attendance by wealth quintile for selected regions .....	25
Figure 4.1. Suchman's five stages of illness and medical care .....	60
Figure 4.2. Andersen's behavioural model of healthcare utilisation .....	64
Figure 4.3. Kroeger's explanatory variables and choice of healer .....	68
Figure 4.4 Dimensions of the duality of structure.....	76
Figure 5.1. Map of India, showing Maharashtra state and Mumbai city .....	90
Figure 5.2. Source of health care in India by rural and urban areas .....	92
Figure 5.3. Trends in prenatal care uptake by residence, India 1998-2006 .....	93
Figure 5.4. The Mumbai Metropolitan Region .....	95
Figure 5.5. Population and growth rate of urban agglomerations in selected Indian cities .....	96
Figure 5.6. Slum clusters in Greater Mumbai, showing ward boundaries – GPS survey 2015-16.....	98
Figure 5.7. Care-seeking pathways from prenatal to delivery care in Mumbai.....	102
Figure 5.8. Choice of health provider for selected symptoms during pregnancy in Mumbai .....	104
Figure 5.9. Map of eastern Mumbai showing SNEHA Centre trial clusters .....	106
Figure 6.1. Explanatory design: participant selection model.....	111
Figure 6.2. Qualitative data analysis and theory generation .....	115
Figure 6.3. SNEHA Centre baseline census: question on location of delivery in English and Hindi.....	126
Figure 6.4. SNEHA Centre baseline census: question on site of institutional delivery in English and Hindi .....	126
Figure 6.5. Example coding of a qualitative interview transcript using Nvivo .....	137
Figure 7.1. Delivery care site, by maternal characteristics, for 3820 deliveries in the two years preceding the study .....	145
Figure 8.1. Theory of manoeuvring .....	153

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**Table 1. Definitions used in the thesis**

Continuum of care	A system that guides and tracks patients over time through a comprehensive array of health services spanning all levels and intensity of care.
Early neonatal death	The death of a baby age 0 to 6 days after birth.
Intrapartum care	The care of healthy women in labour at term (37–42 weeks of gestation).
Late neonatal death	The death of a baby age 7 to 28 days after birth.
Live birth	The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life.
Maternal death	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.
Maternal health	Broadly refers to the health of women during pregnancy, childbirth, and the postpartum period.
Maternal Mortality Ratio (MMR)	Number of maternal deaths per 100,000 live births
Neonatal death	The death of a baby age 0 to 28 days after birth.
Neonatal Morality Rate (NMR)	Number of neonatal deaths per 1000 live births
Perinatal death	Comprises the combination of stillbirths and early neonatal deaths.
Perinatal period	Commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth.
Prenatal care (also known as antenatal care or ANC)	Health care provided by skilled health-care professionals to pregnant women and adolescent girls
Skilled birth attendant	Usually defined as a doctor, nurse, midwife, or auxiliary nurse-midwife who attends a delivery. In some low- and middle income countries, skilled birth attendants might not be fully trained.
Stillbirth	The death or loss of a baby before or during delivery.



## **Ethics**

The SNEHA Centre trial was approved by the Multi-Institutional Ethics Committee of the Anusandhan Trust, Mumbai, in sequential phases: permission for formative research in the development of the trial (February 2011), permission for slum vulnerability assessment and research on cluster gatekeepers (May 2011), permission for the baseline survey (August 2011), and permission for the intervention and evaluation component of the trial (January 2012).

It was also approved by the University College London Research Ethics Committee (reference 3546/001, January 2012).

Trial registration: ISRCTN Register: ISRCTN56183183

Clinical Trials Registry of India: CTRI/2012/09/003004

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## **Chapter 1 Introduction**

### **1.1 Background to the research**

My interest in health care-seeking began while I was working in Peru on a primary health program in Amazonian villages between 1999 and 2003. As part of my work, I developed an understanding of local health issues and patterns of health care-seeking. I observed the pluralistic way in which villagers used natural (plant-based), supernatural (shamanistic), and biomedical treatments for illness. I also noticed their general reluctance to seek health care at government health centres and hospitals (Alcock, 2002). As part of a postgraduate degree in medical anthropology, I conducted subsequent ethnographic fieldwork in an indigenous community in the same region (Alcock, 2006). During my six-week stay in the village, I came to learn that the way people responded to episodes of illness reflected their cultural understanding of health, illness, and beliefs about healers and treatment methods. Treatment often involved visits to different types of practitioner and the sequential or simultaneous use of multiple treatment regimens.

Between 2007 and 2016, I was based in Mumbai working with local and international colleagues on interventions to improve the health of women and children living in Mumbai's informal settlements. We conducted two major randomised controlled trials of community-based maternal health and health care-seeking programmes across the city (Shah More et al., 2012, Shah More et al., 2008, Shah More et al., 2013). In contrast with my experience in isolated areas of the Peruvian Amazon, the research allowed me to observe health care-seeking in a large metropolitan setting. In 2012, I became involved in multi-site research on inequalities in maternal and neonatal mortality (Houweling et al., 2015, Houweling et al., 2014). Part of the research involved analysing patterns of maternal health care uptake and choice of provider in our trial area (see Alcock et al., 2015, in Appendix A). This gave me the opportunity to carry out more in-depth research on maternal health care-seeking in an urbanised, medically plural context.

Most health-seeking models have either been developed in or focused on high-income settings or rural areas of low-income countries. Furthermore, most of the theoretical literature on health-seeking behaviour is related to sickness. On the rare occasions when medical pluralism has been considered in the development of theoretical models, it has primarily been examined in terms of biomedical versus traditional health care providers. Although empirical studies have described levels of access and utilisation of health care services in the public and private sectors, and their associations with key sociodemographic indicators, data on health care providers are usually aggregated. A failure to distinguish between patterns of health care-seeking across multiple levels of health provider overlooks the important organizational and functional features of health systems and how people engage with services. For example, few theories adequately take into account the complex public-private mix common in almost all urban settings (Bennett et al., 1997). In many countries, including India, there are multiple levels of health care provider in both public and private sectors. In order to really understand the complexity of structural factors and reasons for differences in choice and utilisation with health services, it is necessary to study health care-seeking in more detail. Qualitative studies are often descriptive and use thematic analyses to identify the various facilitators and barriers to health care. Many ignore or overlook broader social theories that help frame research design and influence data analysis. Much of the research on health care-seeking has failed to explain why people use or fail to use certain health services. There has been insufficient emphasis on the process of choosing a provider and engaging with services, especially with regard to maternity care.

The thesis reports on research carried out in Mumbai's eastern informal settlements between 2012 and 2015. It is an ambitious attempt to move beyond traditional quantitative and qualitative descriptive analysis of care-seeking patterns towards an empirically-driven understanding of the processes involved in selecting and utilising maternal health care services in a poor urban setting. To this end, my goal was to bring "new evidence to bear on an old issue" (Phillips and Pugh, 1994, in Silverman, 2000: 71).

## **1.2 Role of the researcher**

Between 2007 and 2016, I was based in Mumbai providing technical and research support for the SNEHA Centre trial and subsequent community-based health programmes. My involvement centred on the trial evaluation and mixed-methods research related to maternal and newborn health. The idea for the thesis emerged as a result of this work.

One of my roles in the trial was to develop an electronic data collection system to replace the paper-based system used in the previous trial. This involved consulting with experienced colleagues, developing a needs assessment, and identifying affordable software and devices. I helped design the structure and content of the trial baseline survey which I used to develop an electronic data collection form for smartphones using open source data collection software (see chapter 5.8). I also designed a training plan for field investigators and supervised the piloting of the survey in various field sites.

I was responsible for all phases of the qualitative research, including designing the data collection tools, participant information sheets and consent forms, recruiting and supervising two junior researchers, and developing the grounded theory. I worked with colleagues from UCL and SNEHA on the design, implementation, and some analysis of the trial evaluation, from which the quantitative data in the thesis were derived. I use the collective “we” or “the research team” throughout the thesis to refer to aspects of the research that involved collaboration with colleagues. The role of each member of the collaboration is specified in our published mixed method paper in Appendix A.

SNEHA also facilitated access to the communities, residents, and field staff, and provided the space for focus group discussions. I was granted permission to use socio-economic and demographic data collected during the trial and intervention monitoring in a letter of collaboration (see Appendix B).

### **1.3 Structure of the thesis**

The thesis begins with a background to the research, describing my evolving interest in health care-seeking and my role in the development of the thesis. Chapter two examines the relationship between urbanisation and health care inequalities. Chapter three introduces issues of central concern for global health, including the scale of maternal and newborn health inequalities and patterns of health care utilisation in rural and urban India. Drawing on literature from social psychology, sociology, and medical anthropology, chapter four provides a multidisciplinary review of major theoretical models that attempt to explain and predict a range of health-seeking behaviours. It also introduces debates in sociology on the interrelationship between social structure and individual agency, the concept of structuration, and their relevance to health practice theory. Chapter five describes the setting in which the research took place. It gives a brief introduction to India and, specifically, Mumbai, examining its demographic characteristics including urbanisation and the growth of informal settlements, and the urban health care context. I also describe the community-based health programme within which the study was developed.

In chapter six, I describe the study aims, objectives, and methods, explaining my choice of a mixed quantitative and qualitative design and grounded theory approach. I outline the main principles and process of classic grounded theory and how I applied them. Chapter seven presents the results and a discussion of the quantitative analysis, with reference to the opportunities for follow-up, qualitative enquiry. In chapter eight, I provide a detailed presentation of the theory of manoeuvring, a social practice that explains the process by which women and their families move between various phases in the maternal health care-seeking process. In Chapter nine, I revisit the aims of the research and summarise the main quantitative and qualitative findings. I re-examine the theoretical and health care-seeking literature described in the introduction in light of the study findings, discussing them and their contribution to existing knowledge. I make a parallel with Giddens' (1984) structuration theory and reflexive monitoring. I reflect on my experience of using mixed methods and grounded theory, and describe the study's main strengths and limitations. Chapter ten outlines the study conclusions and recommendations.

## Chapter 2 Urbanisation and health care inequalities

The effect of contemporary global urbanisation on health and health care deserve some attention. The 20<sup>th</sup> century marked a transition from a predominantly rural to urban world and the global proportion of people living in urban areas is projected to increase from 54% in 2015 to 66% by 2050 (World Health Organization and UN-Habitat, 2016). Most of them will live in Africa and Asia. More than 400 million people will live in urban India alone (United Nations, 2014). Although urban growth is associated with economic and social development through the provision of employment, increased production, modern living and cultural practices, and better access to basic public services, higher demand for and utilisation of resources and services creates pressure on the urban environment and infrastructure. The demand to satisfy the increased need often exceeds capacity (Cohen, 2006, Tabibzadeh et al., 1989).

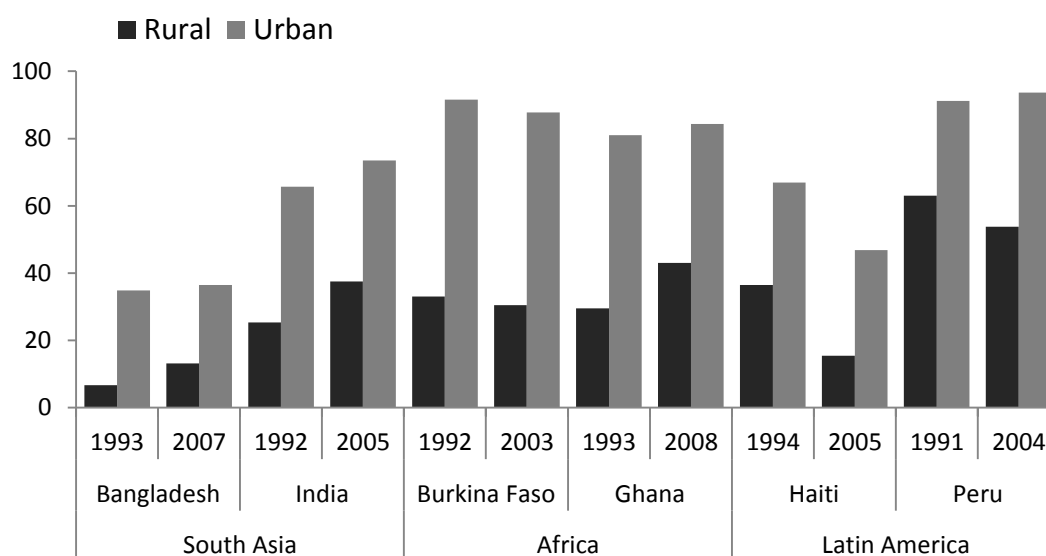
Alongside urbanisation, the proportion of urban residents in low- and middle-income countries living in poverty is increasing. It is estimated to grow faster than the rate of urban population growth so that, by 2020, up to half the urban population will be poor. As a result of this ‘urbanisation of poverty’, a greater proportion of the population will live in informal settlements, or slums (Cohen, 2006, Moreno, 2003, Vlahov et al., 2007). UN-HABITAT defines a slum household as “a group of individuals living under the same roof that lack *one or more* of the following conditions: insecure residential status, inadequate access to safe water, inadequate access to sanitation and other infrastructure, poor structural quality of housing and overcrowding” (Moreno, 2003: 8, italics in original).

Urbanisation also affects patterns of disease and demand for health services. There is some debate as to whether living in a town or city is an advantage or disadvantage. On average, health indicators are better in cities than in rural areas (Harpham, 2009, Montgomery, 2009). However, this tends to be more so in countries with narrower gaps between the wealthy and the poor, and where there are greater levels of social support and social cohesion (Vlahov et al., 2005). Disaggregated data, however, show that the urban poor often face similar or worse health risks than rural residents. Urban populations are socially and economically heterogeneous and are exposed to

different health system dynamics, including more diverse medical systems, a more dominant private sector, and greater monetisation of health (Montgomery, 2009). Urban growth and unequal access to resources can create a divide between those who can meet or exceed their needs and those who cannot. The result may be that the urban poor become economically, socially, and spatially isolated, and deprived of many of the resources enjoyed by other city residents, such as adequate water and sanitation, electricity, sewage disposal, and access to services like schools, employment, and health care (Harpham and Molyneux, 2001).

The characteristics of cities, including size, density, diversity, and complexity (Vlahov et al., 2007), present a particular set of opportunities and challenges regarding the provision and utilisation of urban health care. Living in a town or city can improve accessibility because of the concentration of infrastructure and proximity of health services (Cohen, 2006, World Health Organization, 2000). There are, however, global disparities. For example, Figure 2.1 shows the coverage of skilled birth attendance in urban and rural areas in six countries in South Asia, Africa, and Latin America.

**Figure 2.1. Coverage (%) of skilled birth attendance in urban and rural areas for selected regions**



(Source: World Health Organization, 2016b)

While coverage in each country is substantially higher in urban than in rural areas, the difference varies considerably across countries. In most, skilled birth attendance has increased in both rural and urban areas, although in some, such as Bangladesh and Haiti, urban coverage is lower than rural coverage in others.

Greater availability of health care infrastructure in towns and cities means that residents have access to a more comprehensive range of facilities, equipment, technology, and specialised services. There is also a wide diversity of health care models, healing methods, health care providers, along with a wide range of costs. Although the health needs of the urban poor are primarily the responsibility of the public health system, health services in urban areas encompass a diversity of providers (Harpham and Molyneux, 2001, Lorenz and Garner, 1995). These include government facilities, non-governmental organizations and trusts, as well as a range of private providers.

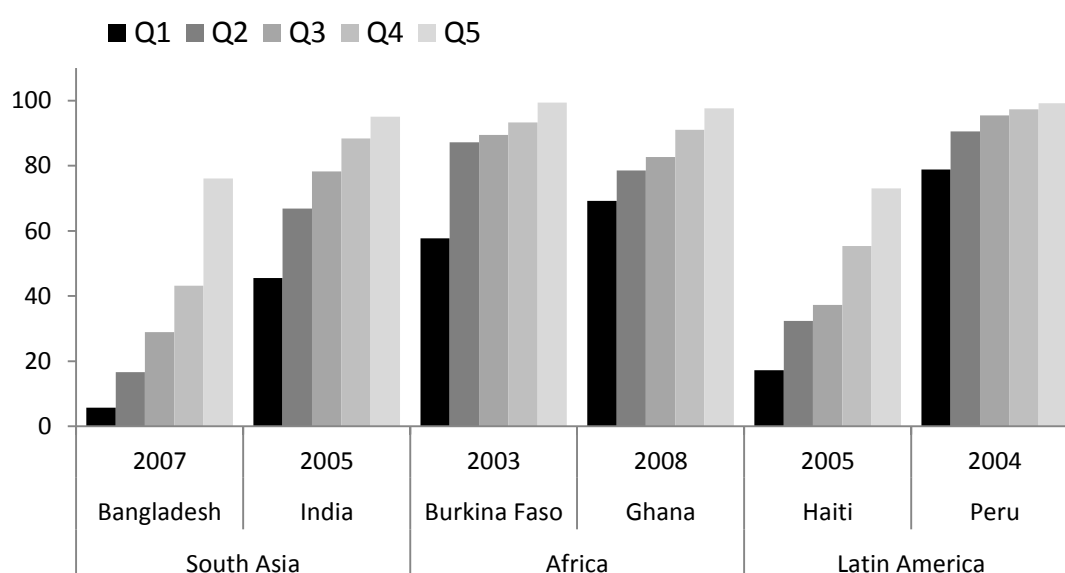
Studies in many low- and middle-income countries have shown the predominance of private sector health care in urban areas (Hanson and Berman, 1998, Palmer et al., 2003). Poorer groups depend on good health and wellbeing for economic and household stability, but social and financial constraints mean that they often seek health care from more accessible, lower quality providers who are less competent and make less effort (Das et al., 2008). This is a concern because of the potentially harmful effects of over-medication, inappropriate treatment, or ignoring minimum standards of care (Barua, 2005, Bazant et al., 2009). The urban poor often face the difficult choice between an inadequately supplied and trained public sector with brusque staff attitudes, and having to spend a high proportion of their income in the private sector, which might not provide higher quality care (Harpham, 2009).

Despite the greater accessibility of health services in urban areas, unequal coverage and utilisation between poorer and wealthier groups is a persistent problem. For example, Figure 2.2 shows disparities in coverage of skilled birth attendance between wealth quintiles in urban areas of the six countries shown in Figure 2.1 above. Overall, systematic inequalities exist between and within all countries. In every country, the poorest group (Q1) has lower access to care than the wealthiest (Q5) and



this is most marked in poorer countries where coverage is generally much lower, such as Bangladesh and Haiti.

**Figure 2.2. Coverage (%) of urban skilled birth attendance by wealth quintile for selected regions**



(Source: World Health Organization, 2016b)

An uneven distribution of health facilities can also affect equity because disadvantaged groups often live in poor underserved neighbourhoods (Balarajan, Selvaraj & Subramanian, 2011). In some cases, urban women from the poorest socio-economic groups have less skilled maternity care than some wealthy groups in rural areas (Matthews, Channon, Neal, Osrin, Madise & Stones, 2010). The urban poor can find care difficult to access even when well-functioning health infrastructure is located nearby. People of lower socio-economic status and other marginalised or minority groups (e.g. undocumented migrants) are less likely to have health insurance, face barriers to accessing health care, and often receive poorer quality care.

This chapter has reflected on projections of rapid global urbanisation, including in India, and the effect it is likely to have on urban poverty, expansion of informal settlements, and increasing demand for health services. I also provided evidence of

inequitable maternal health care coverage in low- and middle-income countries. In the next chapter I examine in detail global and Indian maternal and newborn health, maternal health care guidelines, and patterns of maternity care-seeking in rural and urban India.

## **Chapter 3 Global and Indian perspectives on maternal health care utilisation**

This chapter has three main objectives: (1) to provide an overview of the epidemiology of maternal and perinatal health, globally and in India; (2) to describe current global and Indian guidance for maternity care; (3) to explore patterns and determinants of maternal health care utilisation in India.

### **3.1 Literature search**

I developed a comprehensive literature search strategy using terms related to maternal and perinatal health, mortality, and maternal health care-seeking in South Asian countries, including India. I searched five academic databases: PubMed, EBSCOHost, Web of Science, the International Bibliography of the Social Sciences (IBSS), and Google Scholar. I filtered the searches using Boolean operators and by specifying geographical locations (South Asia and individual countries) and custom date ranges (generally from 2000, except for maternal health care utilisation in India, which I restricted to 2005-2018 to include the two most recent Indian Demographic and Health Surveys [DHS] and related articles). To further optimise some search results I used bracketed terms to search specific fields (e.g. article title, abstract, subject keyword). I restricted the search to published articles in international peer reviewed journals that used qualitative, quantitative, or mixed methods and either primary or secondary data, and that were written in English. Because of a lack of recent research on social and cultural dimensions of maternal health care-seeking (for example, maternal autonomy) in India, I included some relevant articles published prior to 2005.

I used combinations of Medical Subject Headings (MeSH on PubMed) and open search terms (with and without filters and Boolean operators) to expand and refine results (see Box 1).

**Box 1. Medical Subject Headings (MeSH) and open search terms used in the literature review**

**MeSH terms (PubMed):** Maternal Health; Maternal Mortality; Perinatal Mortality; Perinatal Care; Pregnancy; Prenatal Care; Pregnancy Outcome; Stillbirth; Delivery, Obstetric; Maternal Health Services; Developing Countries, India

**Open terms:** ‘maternal health’; ‘maternal health services’; (‘maternal healthcare’ OR ‘maternal health care’ OR ‘maternal health care seeking’ OR ‘maternal health care-seeking’ OR ‘maternal health care utilisation’ OR ‘maternal health care utilization’); (‘prenatal care’ OR ‘antenatal care’); ‘delivery care’; ‘facility-based delivery’; ‘skilled birth attendance’; ‘perinatal care’; ‘continuum of care’; ‘safe motherhood’

I also searched for regional and country data, published reports, and policy guidelines on the websites of global health institutions such as the World Health Organization (WHO: [www.who.int](http://www.who.int)), United Nations Children’s Fund (UNICEF <https://unicef.org/>), and the WHO Global Health Library (<http://www.who.int/library/en/>). I searched Indian Government websites including the Ministry of Home Affairs Census of India (<http://www.censusindia.gov.in/>) and the Ministry of Health and Family Welfare National Health Mission (<http://nhm.gov.in/>) for information on health programmes and guidelines, including the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM), and the National Family Health Survey website (<http://rchiips.org/nfhs/>) for access to publications from India’s National Family Health Survey (NFHS), the equivalent of the DHS. Finally, I used the British Library e-thesis online repository (<http://ethos.bl.uk>) to search for PhD theses on maternal health care utilisation in South Asia.

## **3.2 Maternal and perinatal health: global and Indian progress**

### **3.2.1 Global epidemiology of maternal and perinatal health**

Approximately 140 million births occur globally every year (World Health Organization, 2018c). Although the number of maternal deaths has halved over the past two decades, according to recent estimates, more than 300,000 women died in 2015 from complications during pregnancy or childbirth (World Health Organization, 2018a). In addition, an estimated 2.6 million neonatal deaths (of which more than 2 million occur within the first week of life) and 2.6 million stillbirths

occur annually (UNICEF, 2018). The United Nations has officially recognised the unacceptably high burden of maternal mortality and morbidity as not only a global health or development issue, but also as a human rights issue (United Nations Population Fund, 2012).

Most deaths occur during the perinatal period, which commences at 22 completed weeks of gestation and ends seven completed days after birth (World Health Organization, 2012). In addition to the high number of global perinatal deaths, the burden of mortality is highly unequal. Most deaths occur in poorer nations, and the maternal mortality ratio is 14 times greater in low-income than in high-income countries (World Health Organization, 2014). Almost all neonatal deaths globally occur in less developed regions (World Health Organization, 2018a). Substantial differences in mortality also exist between regions (McKinnon et al., 2016, Wang et al., 2014). Sixty-two percent of all maternal deaths occur in Sub-Saharan Africa, followed by 24% in South Asia (Lander, 2006).

Medical causes of mortality can be direct or indirect. Direct causes refer to complications directly related to pregnancy, childbirth, and postpartum, deriving from interventions, omissions, incorrect treatment, or a combination of these. Indirect medical causes are complications that arise due to pre-existing conditions (World Health Organization, 2007b). The most common medical causes of neonatal death in low-income countries are prematurity and low birth weight, birth trauma, asphyxia, and infections (Fottrell et al., 2015, Iwamoto et al., 2013, World Health Organization, 2018b). Most maternal deaths are from direct causes including hypertensive disorders, abortion, haemorrhage, and sepsis (Kassebaum et al., 2014, Neal et al., 2016, Omrana et al., 2018). Globally, indirect causes of maternal morbidity and mortality account for approximately 25% of maternal deaths and near-misses (World Health Organization, 2016a). Crucially, most of these deaths, especially those caused by indirect factors, are avoidable.

Non-medical causes also make a significant contribution to poor health outcomes and premature death, but are varied and complex. In low- and middle-income countries, socio-economic and demographic inequalities play an important role. For example, low education and inadequate prenatal care are associated with higher risks of

maternal death (Bauserman et al., 2015). A study in 11 diverse low- and middle-income countries reported significantly and consistently higher rates of maternal deaths among the poorest mothers (Graham et al., 2004). Health system deficiencies, such as inadequate or low quality care, are equally important (Bauserman et al., 2015, Ronsmans and Graham, 2006). For example, low service coverage, whereby health services and interventions do not reach those who need them, has been linked to under-five mortality (Kumar et al., 2013). In rural areas, poor physical access to maternal health services is often an important underlying cause of mortality (Ronsmans and Graham, 2006). Combined, these inequalities and system deficiencies can make access difficult and result in underutilisation of crucial health services such as emergency obstetric care. Countries have reduced mortality by investing in the health sector, improving health service coverage (especially for poor and marginalised groups), mobilising multi-sectorial partnerships, using evidence-based health planning and decision-making, and making improvements in other social, economic, and environmental determinants of health (Bishai et al., 2016, Jack et al., 2014, Victora et al., 2017).

Recent global analyses of maternal and newborn health indicate an overall improvement in the coverage and utilisation of services in low- and middle-income countries, although progress has been uneven. A systematic analysis of secondary data from 183 countries found a 43% global increase in coverage of care in the first trimester of pregnancy (early prenatal care) from 41% in 1990 to 59% in 2013 (Moller et al., 2017). Despite these improvements, the study found substantial variations in service coverage between countries. For example, in high-income countries, early prenatal coverage was 82%, whereas in low-income countries it was as low as 24%. These disparities continued throughout the period of analysis. Therefore, although the global picture is one of overall progress, important geographic and socio-economic inequalities persist.

Marginalised groups and individuals in economically poor countries often underutilise services, including prenatal and delivery care. A meta-analysis of DHS data from 45 low- and middle-income countries reported that wealthier women were much more likely to have prenatal care and to deliver with a skilled attendant (usually a doctor, nurse, midwife, or related health worker, who might or might not

actually be fully ‘skilled’) than poorer women (Houweling et al., 2007). Several country-level studies support these findings. For example, in Nigeria, women in the highest household wealth quintile were at least seven times more likely to deliver in a health facility than women in the lowest (Ononokpono and Odimegwu, 2014), and in Cambodia the wealthiest women were almost 12 times as likely to do so (Chomat et al., 2011).

### **3.2.2 Maternal and perinatal health in India**

India has made considerable progress towards improving the health of women and newborn infants. Between 1990 and 2013, the maternal mortality ratio (MMR) declined by 65% from 560 maternal deaths per 100,000 live births to 190 (World Health Organization, 2014). Although this is a significant achievement, reductions have been slower than in many other Asian countries and, with an annual 45,000 maternal deaths (15% of the global total), India still has the largest number of maternal deaths worldwide (Graham et al., 2016). According to the most recent round of India’s National Family Health Survey (NFHS-4), the neonatal mortality rate is currently 30 deaths per 1000 live births and the perinatal mortality rate (perinatal deaths include stillbirths and early neonatal deaths) is 36 per 1000 births (International Institute for Population Sciences and ICF, 2017).

The medical and non-medical causes of maternal and neonatal deaths in India are similar to those reported in other low- and middle-income countries. A common method to establish the cause of death in countries that lack a comprehensive vital registration system is verbal autopsy, which involves interviewing the deceased person’s family or other caregivers (Soleman et al., 2006). The One Million Deaths Study conducted verbal autopsies for up to a million deaths in India over two phases (1998-2003 and 2004-2014) to document the underlying causes of child and adult deaths, as well as key risk factors (Jha et al., 2005). Of the 1096 maternal deaths reviewed up until 2003, 84% were due to direct causes and 16% were indirect. Specifically, more than 80% were attributed to direct obstetric causes, mainly intrapartum haemorrhage, but also infection and other obstetric and pregnancy-related complications (Montgomery et al., 2014). Many neonatal deaths were also related to events in the intrapartum or immediate postnatal period; 78% were attributed to three causes: prematurity and low birthweight, neonatal infections, and

birth asphyxia and birth trauma (The Million Death Study Collaborators, 2010). These outcomes are strongly influenced by mothers' health during pregnancy, childbirth, and postpartum, which is also influenced by health service-related factors. In addition to medical causes, social determinants including young age at marriage and childbirth, short spaces between births, low female literacy among the rural and urban poor, and poor access to contraception and safe abortion services are major contributors to maternal and child mortality in India (Ministry of Health and Family Welfare, 2013a).

In India, maternal and neonatal mortality are unequally distributed. Rural states and the most deprived regions within them have the highest burden. According to the Million Death Study, three quarters of all maternal deaths from 1998 to 2003 occurred in rural areas of poorer states and the maternal mortality rate in rural areas was estimated to be more than three times that of the lowest rates found in urban areas of wealthier states (Montgomery et al., 2014). In the recently-published NFHS-4, the perinatal mortality rate was estimated at 40 deaths per 1000 pregnancies in rural areas, compared with 26 per 1000 in urban areas. Perinatal and neonatal mortality rates were highest in northern, central, and eastern states. Uttar Pradesh (north-eastern India) recorded the highest neonatal mortality rate (56 per 1000) and Kerala (Southern India) the lowest (8 per 1000) (International Institute for Population Sciences and ICF, 2017). Other studies have reported rural neonatal mortality rates at least twice those of urban areas (see for example, Kulkarni et al., 2007, Kumar et al., 2014).

In a cross-site verbal autopsy study in rural areas of India, Bangladesh, and Nepal, Fottrell and colleagues (2015) estimated the neonatal mortality rate among tribal villages in Jharkhand and Odisha to be 59 per 1000 live births, almost seven times the rate in informal settlements of urban Mumbai. Infections and prematurity each accounted for approximately one-third of neonatal deaths in rural areas. While these were also prominent causes of death among communities in Mumbai's informal settlements, birth asphyxia was the major cause. Causes of death also seem to follow an unequal pattern of distribution. In 2005, mortality from neonatal infections was almost four times greater in central states compared to southern states; central states



also had the highest rates of birth asphyxia and birth trauma (The Million Death Study Collaborators, 2010).

That many of these deaths are avoidable alludes to the importance of accessible and adequate health care in both rural and urban areas. Moreover, the greater contribution of obstetric complications to deaths in urban areas highlights the need for timely and appropriate utilisation of maternity care. However, the availability of services does not necessarily lead to adequate or efficient intervention. A qualitative analysis of events prior to death in the same Mumbai dataset used by Fottrell and colleagues reported excessive waiting times at health facilities, refusal to admit some women in labour, poor provider behaviour or inappropriate treatment, and inefficient referrals as potential sources of health system delay. Two-thirds of caregiver narratives described delays related to the provision of health care in the facility (Bapat et al., 2012).

The decline in maternal mortality in India cannot be explained solely by an increase in coverage of services (Kesterton et al., 2010). Although maternal mortality has declined in most states where institutional deliveries have increased, this does not hold true for all states (Kumar et al., 2010). Goli and Jaleel (2013) have argued that socio-economic development and improvements in demographic indicators are more strongly associated with the decline in mortality than institutional delivery. NFHS-4 data also show that perinatal mortality rates decline with increases in mothers' education and household wealth. Mortality ranges from 48 deaths per 1000 pregnancies in the lowest wealth quintile to 21 per 1000 in the highest (International Institute for Population Sciences and ICF, 2017).

### **3.3 The case for maternity care**

In India, motherhood is both a biological and sociocultural accomplishment and transformative rite of passage for young and newly-married women (Naraindas, 2009). Besides, the biological imperative of reproduction, fertility and the birth of a healthy child (especially a male) strongly influences women's social status (Miller, 2005). Because of the significance of pregnancy and childbirth, ensuring a successful outcome becomes a crucial factor underlying all maternal health care decisions.

Uptake of maternal and neonatal health services improves outcomes, survival, quality of life, and infant health (Moller et al., 2017). There is, however, some debate on the precise contribution that institutional maternity care has in improving health outcomes. Some researchers have argued that there is insufficient evidence to confirm the effectiveness of prenatal intervention (McDonagh, 1996). Others point out that early contact with a health care provider is an opportunity to confirm gestational age, detect genetic and congenital disorders, prescribe folic acid supplements, and treat anaemia and sexually transmitted infections. The early management of potentially harmful conditions during pregnancy can potentially reduce the risks for women and newborn infants during and after the birth (Moller et al., 2017, World Health Organization, 2018a).

Adverse maternal health outcomes are also linked to late initiation or low frequency of prenatal care. These include inadequate gestational and postnatal weight gain, premature rupture of membranes and precipitous labour, failure to breastfeed, postnatal underweight, and pre- and postnatal smoking (Yan, 2017). Further preventive interventions and services include vaccinations as well as providing information for health promotion and risk prevention during pregnancy (Stephenson and Matthews, 2004). Regular consultations also offer the opportunity for health providers to build rapport with pregnant women and encourage them to continue seeking health services, especially during labour or in case of serious complication (Acharya, 1995, Arokiasamy and Pradhan, 2013). Prenatal interventions might have individual or cumulative effects. One study compared combinations of three components of prenatal care (four or more visits, two or more tetanus toxoid injections, and consumption of 90 or more iron and folic acid tablets) with neonatal survival in India (Singh et al., 2014a). The study concluded that, while the risk of neonatal mortality was significantly lower for infants of mothers who received any of the three prenatal care components, tetanus toxoid injections provided the most protection.

Most maternal deaths occur around childbirth. As described above, contributory factors include various direct and indirect medical and social causes. There is considerable evidence that skilled birth attendance can reduce morbidity and mortality (Stephenson and Matthews, 2004, Thaddeus and Maine, 1994).

International health organisations and policy-makers emphasise the role of trained health professionals with access to equipment and medicines in facilitating safe labour and managing obstetric complications (World Health Organization, 2009). Unsurprisingly, global efforts to reduce maternal and perinatal morbidity and mortality have prioritised the promotion of institutional maternity care (Thind et al., 2008). These initiatives emphasise that care-seeking during pregnancy should not end with prenatal care but lead to a safe delivery in an appropriate environment. Ensuring the effective use of institutional delivery care requires an adequate distribution of infrastructure and services, access to emergency obstetric care, and skilled birth attendance (Rosenfield et al., 2007). Importantly, Gulliford (2002) distinguishes two types of access to health care: *having* access is the potential to obtain care when it is wanted or needed, while *gaining* access is the process of actually utilising services. The latter can be made challenging for financial reasons, personal reasons (such as attitudes to and experiences of care), or organisational reasons including waiting times and direct and indirect costs of care. However, even when services are accessible, they are not necessarily utilised, utilisation is highly inequitable, and it does not necessarily lead to the delivery of good quality care.

In the following section, I review some of the international and Indian guidelines on recommended maternal health care practices, then move on to describe dominant patterns of maternal health care utilisation in India.

### **3.4 Global and Indian guidance on maternity care-seeking**

#### **3.4.1 International policy and guidelines**

Recommended practices and components of health care vary across countries and contexts, for example in the optimal number of prenatal consultations, immunisations, nutrition supplements, the location and management of childbirth, and the people who should assist at birth (Banke-Thomas et al., 2017). Although international and local policies and guidelines on recommended maternity practices exist, the absence of universal standards suggests a lack of consensus on what optimal or complete packages of health care should include. The WHO is responsible for setting international standards. The most recent WHO guidelines outline 49 recommendations for a “positive pregnancy experience”, classified into five types of

intervention and their components: (1) nutritional interventions including dietary advice and provision of iron and folic acid supplements, (2) maternal and foetal assessment, (3) preventive measures such as tetanus toxoid vaccination, (4) interventions for common physiological symptoms including nausea and vomiting, heartburn, and lower back or pelvic pain, and (5) health system interventions aimed at improving the utilization and quality of care (World Health Organization, 2016a). These recommendations now incorporate women's own definitions of "positive experience", including physical and sociocultural normality, a healthy pregnancy for mother and baby, effective transition to positive labour and birth experience, and positive motherhood.

The WHO guidelines recommend a minimum of eight prenatal contacts with skilled care providers and that the first contact should happen within the first three months of pregnancy (World Health Organization, 2018a). This supersedes the previous WHO recommendation of four or more prenatal visits (World Health Organization, 2007a). The term "contact" is now preferred to "visit" because it implies "an active connection between a pregnant woman and a health-care provider" (World Health Organization, 2016a: 101). The new recommendations have been developed from evidence that lower frequency of contact is associated with higher perinatal mortality and greater frequency with the likelihood of detecting health problems, improving provider communication, and better support for pregnant women and their families. A related WHO publication identifies 59 recommendations for positive labour and intrapartum care, including clinical interventions during the various stages of labour, care of the newborn, and women's postpartum care (World Health Organization, 2018c). Also recommended are four non-clinical actions during labour and birth, including ensuring respectful care and maintaining the woman's dignity, privacy, and ability to make informed choices; providing adequate information through effective and culturally acceptable communication; and encouraging the presence of a chosen companion during labour and birth.

These WHO guidelines somewhat counter the medicalisation of maternity and emphasise pregnancy and childbirth as normal physiological processes. They acknowledge that women's experiences of health services, including the recognition their own presence, capacity, and control over labour and childbirth, are central to

the ideal of high quality care. Along with the recognition of maternal health as a human rights issue, which is also reflected in UN Sustainable Development Goal 3 (United Nations, 2017), these current policies and practices mark a shift away from interventions that seek only to avoid the medical causes of maternal death and morbidity towards the provision of universal, women-centred health and wellbeing.

### **3.4.2 National policy and guidelines**

In India, the Ministry of Health and Family Welfare is the main body responsible for defining and implementing health policy and practices. A number of documents and guidelines exist for health facility staff and community-based frontline workers. India's most recent national strategy for reproductive, maternal, newborn, child, and adolescent health (RMNCH+A) sought to address the principal medical causes of mortality and delays in accessing and utilising health services (Ministry of Health and Family Welfare, 2013a). Among its targets were a doubling in the number of health facilities equipped to manage perinatal care, a 5.6% increase in the proportion of births at public and accredited private health facilities, a six percent increase in the proportion of women receiving prenatal care, and a two percent increase in the proportion of deliveries attended by a skilled birth attendant from 2012 to 2017. The RMNCH+A prioritised underserved groups, including the urban poor.

High population density in urban areas presents specific challenges and opportunities for health and health care. On one hand, towns and cities experience higher concentrations of ill-health and inequitable access to health care. On the other hand, there is a greater supply of diverse types and levels of health provider. The RMNCH+A proposed to strengthen existing public health institutions, establish primary health centres with amenable opening hours close to informal settlements and referral health centres with in-patient services, and public health laboratories in larger cities. It also planned to create pro-poor partnerships with public, non-government, and private providers to coordinate the delivery of health services. Frontline workers called Urban or Accredited Social Health Activists (USHAs or ASHAs) and community-based women's groups (*Mahila Arogya Samiti*), managed under the National Urban Health Mission (Ministry of Health and Family Welfare, 2013b, 2014), provide outreach information, referral services, and organise community mobilisation activities to generate greater demand for health services.

The Ministry of Health and Family Welfare guidelines for skilled birth attendants outlines optimal prenatal and delivery care practices (Ministry of Health and Family Welfare, 2010). It recommends that women register their pregnancy and initiate prenatal care within 12 weeks of conception, make at least four visits, receive tetanus toxoid immunisations and iron and folic acid supplements, have routine blood tests, and have blood pressure and weight taken at every visit. It recommends institutional delivery, but adds that a skilled birth attendant should be present if a woman chooses to give birth at home. Women who are planning an institutional delivery are advised to register at the planned health facility during the first prenatal visit. Upon registration, they normally receive a Mother and Child Protection (MCP) Card as a record of maternal and child health services provided. The card also contains maternal and child health information and visual messages on maternal risks and health-promoting practices. In the postpartum period, women are expected to remain in the health facility for a minimum of 48 hours and receive a postpartum check-up within two days of birth.

The Indian government has implemented several national initiatives under the National Health Mission (NHM). The NHM has a rural component (the National Rural Health Mission, or NRHM) and an urban component (the National Urban Health Mission, or NUHM). The NUHM was launched as a response to the challenges of rapid population growth and urban health demand in India (Ministry of Health and Family Welfare, 2013b). An extension of the older NRHM programme, the NUHM aims to address the health concerns of the urban poor by facilitating equitable access to health care by strengthening the public health care system for vulnerable groups, including residents of informal settlements.

The Indian government has also introduced a number of national health programmes specifically aimed at improving maternal and newborn health. Two notable schemes are the *Janani Shishu Suraksha Karyakram* (JSSK) and the *Janani Suraksha Yojana* (JSY). The JSSK was introduced in 2011 and entitles all pregnant women to free institutional delivery care in public health facilities, ambulance transport between home and health facility, and transport between facilities if referral is necessary. The aim is to reduce financial and transport constraints that cause families to delay care-seeking (Ministry of Health and Family Welfare, 2013a). The JSY was launched

earlier, in 2005, under the NRHM (Ministry of Health and Family Welfare, 2006) and is one of the world's largest conditional cash transfer schemes. Under the scheme, women from low socio-economic groups can receive cash assistance to utilise skilled maternity services. It is anticipated that increasing uptake of skilled care will lower maternal and infant mortality. All women from Low Performing States (LPS, i.e. states with low institutional delivery rates) and poor women from other states are eligible who give birth at a public health facility or an accredited private institution. Women who deliver at home with a skilled provider are offered a lower amount. Cash incentives for institutional delivery vary from 600 Rupees (~USD 9) for urban mothers in non-LPS to 1,400 Rupees (~USD 20) in LPS. ASHAs are also incentivised to raise awareness of the scheme, encourage women to enrol, refer them to health facilities for delivery, and help arrange transport.

In the context of the international and national guidelines outlined above, the next section explores actual patterns of maternal health care utilisation in India and the determinants that underlie them.

### **3.5 Patterns and determinants of maternal health care utilisation in India**

Maternal health care in India has been studied from the perspectives of both provision and uptake of services. Kumar et al. (2013) reviewed three waves of national survey data from 1992-3 (NFHS-1), 1998-9 (NFHS-2), and 2005-06 (NFHS-3) to estimate gaps in service coverage (services provided in relation to requirements). The study analysed four key maternal and neonatal health indicators, including receipt of three or more prenatal consultations and delivery with a skilled birth attendant (defined as a doctor, nurse, midwife, or auxiliary midwife). The overall gap in the provision of services for skilled birth attendance was 44%. It was 39% for prenatal care. Importantly, the overall shortfall in service coverage reduced only minimally between 1992 and 2006.

Overall, use of facility-based care for prenatal and delivery care has steadily increased over the last 15 years (Sanneving et al., 2013). Comparing various NFHS rounds, Arokiasamy and Pradhan (2013) showed that the proportion of women who received three or more prenatal consultations during pregnancy grew from 43%

(1992-93) to 52% (2005-06). Institutional delivery during the period also increased at a slightly higher rate, from 26% (1992-93) to 39% (2005-06).

Recent data on service uptake provide a more encouraging picture. According to the NFHS-4, 85% of women aged 15-49 who had a live birth in the previous five years registered their pregnancies at a public or private health facility. Although 79% of women received prenatal care at least once from a skilled provider, only 51% received four or more consultations. Delivery care was high: approximately 79% of women surveyed delivered in a health facility, and less than a quarter delivered elsewhere, mostly in their own or their parents' home (International Institute for Population Sciences and ICF, 2017). These data indicate that overall utilisation of both prenatal and delivery care in India continues to rise since the introduction of the JSY. I examine this possibility in more depth in section 1.5.5.

Despite improvements, coverage and utilisation of maternity care in India is unevenly distributed (Kumar et al., 2013). In the following sections, I describe some of the major variations.

### **3.5.1 Variation in choice of provider**

Most studies tend to report maternity care utilisation in terms of uptake and overlook choice of sector and type of provider. This is an important oversight: India has several systems of medicine and pluralistic health care. In addition, Indian women do not necessarily seek maternity care in the same sector or with the same provider throughout their pregnancy (Shah More et al., 2009a). According to the NFHS-4, among all women who made four or more prenatal care visits, more visited a mix of public sector and private sector or non-governmental organisation (NGO) providers than those who saw providers in one sector alone. Interestingly, those who made fewer visits during pregnancy tended to use the public sector only, compared with private or NGO providers. Nationally, the public sector was the most common site for delivery care (52%) and was twice as popular as the private sector (26%). The difference between public and private births decreased with lower birth order, suggesting that women who have had fewer pregnancies and less experience of maternal health care preferred to deliver with a private provider. In addition, women who had more prenatal visits had had more schooling, while those who opted for a



private sector delivery belonged to wealthier economic groups (International Institute for Population Sciences and ICF, 2017).

Pathak et al. (2010) analysed changes in patterns of skilled delivery care in the public and private sectors over three rounds of the NFHS, from 1992 to 2006. Overall, use of the private health sector for delivery care increased at a greater rate than for the public sector. The increase in institutional delivery seemed to be largely attributable to the expansion of the private sector (Pomeroy et al., 2014). Although the use of public health facilities remained comparatively higher among women from wealthier households, among poorer women the use of public sector delivery care declined, and private care increased. In rural areas, deliveries in the private sector more than doubled during 1992–2006, from 7% to 16%, while in urban areas they increased from 29% to 40% (Pathak et al., 2010). Although the use of public facilities among rural mothers of all socio-economic groups remained low and unchanged, it declined significantly among all groups of urban mothers in favour of private care. Since the introduction of conditional cash transfer programmes such as the JSY and JSSK, utilisation of public sector maternity care has increased, especially in rural areas. According to the latest NFHS-4 census, 54 % of rural deliveries and 46% of urban deliveries were in public sector health facilities, compared with 20% and 42% in private institutions (International Institute for Population Sciences and ICF, 2017).

### **3.5.2 Regional and state variations**

Several studies have noted marked regional and state inequalities in maternal health service use. Coverage and uptake of prenatal and delivery care are consistently and substantially lower in north-eastern, central and eastern regions than in more developed states in the south (Ghosh, 2011). Using data extracted from the NFHS-4, table 2 summarises patterns of institutional prenatal and delivery care across the six Indian geographical regions (by combining states into their respective region) and levels of uptake in the highest and lowest performing states.

**Table 2. Uptake of institutional prenatal and delivery care in India, by geographical region, and rates in highest and lowest performing states**

	Four or more prenatal visits (%)			Institutional delivery (%)		
	Average	Highest	Lowest	Average	Highest	Lowest
North	58.2	81.3	30.9	82.7	91.6	68.6
Central	40.4	59.1	26.4	72.9	80.8	67.8
East	45.8	76.4	14.4	71.6	85.3	61.9
Northeast	50.9	74.7	15.0	66.3	94.7	32.8
West	74.0	89.0	62.7	90.8	96.9	88.0
South	81.8	92.1	70.1	96.4	99.9	91.5

Source: data extracted from the National Family and Health Survey (NFHS-4), 2015-16

The data show that the proportion of pregnant women who receive four or more prenatal care visits is highest in southern (82%) and western regions (74%), and much lower in central (40%), eastern (46%), and north-eastern regions (51%). State disparities in the same region are also substantial. For example, the highest rate for prenatal care among eastern states was in West Bengal, where 76% of women reported making four or more visits. In comparison, Bihar recorded the lowest rate in the region with only 14% making the same number of prenatal visits. Similarly, in the North-east, uptake of prenatal care in Sikkim was 75%, compared with 15% in Nagaland (International Institute for Population Sciences and ICF, 2017). Similar patterns occur with institutional delivery. The proportion of women having facility-based births was higher in western and southern states than in central, eastern, and north-eastern states, where within-state disparities were also higher. Disparities in better performing states in the West and South tend to be considerably lower. It is also notable that institutional care-seeking in the highest performing state of some regions still falls below that of the lowest performing state in other regions. For example, although institutional delivery in the central states reached 81% (Madhya Pradesh), it was still below the 92% achieved by the lowest performing southern state (Telangana) (International Institute for Population Sciences and ICF, 2017).

Other studies have reported similar disparities. For example, Kumar et al. (2013) estimated that absolute coverage gaps during 2005–06 were higher than the national average (57%) in the north-eastern (66%), central (66%), and eastern (61%) regions. Arokiasamy and Pradhan (2013) noted enormous differences in uptake between highest and lowest performing states. Analysis of District Level and Household and Facilities Survey (DLHS) showed similar regional levels of prenatal care uptake in

2007-08, with slightly narrower disparities in institutional delivery care (Singh et al., 2014b).

### **3.5.3 Rural and urban disparities**

Institutional delivery in rural India has been historically very low, and studies have shown that coverage for both prenatal and delivery care for urban women can reach at least twice that for rural women. Kumar et al. (2013) reported a coverage gap of 45% in rural areas for prenatal care, compared with 22% in urban areas, and a rural-urban gap of between 21% and 52% for skilled birth attendance. However, recent national census data suggest that rural utilisation rates are increasing. According to the NFHS-4, three-quarters of pregnant women in rural India now make at least one prenatal care visit to a skilled provider and deliver in a health facility, compared with 89% of urban women (International Institute for Population Sciences and ICF, 2017).

Despite these increases, regional disparities persist. Lower levels of institutional maternity care have generally been reported among rural populations in poorer and less developed states than in others. Again, central and eastern regions provide notable recent examples. The proportion of women who sought prenatal care with a skilled provider was as low as 49% in Bihar and 58% in Arunachal Pradesh in 2015-16, compared with more than 90% in each of the southern states (International Institute for Population Sciences and ICF, 2017). In the central state of Madhya Pradesh, where 73% of the population is rural, only around half of women sought skilled birth attendance for their last birth (Jat et al., 2011).

Geographical isolation and poor physical access to health facilities in rural areas are important barriers to utilisation. Economically deprived states are particularly underserved by health services (Kesterton et al., 2010). Physical access to health care is only one of a complex array of determining factors. A qualitative study of poor rural communities in rural Karnataka reported that aspects of autonomy, access to transport, perceived quality of facilities, access to incentive-based health programs, and poverty all influenced decisions to seek maternal health care (Vidler et al., 2016). Despite longer distances to health facilities and arduous terrain, socio-economic factors can be a stronger indicator of institutional delivery among some rural populations (Kesterton et al., 2010). Furthermore, in states where overall

maternal care-seeking is relatively high, disparities between rural and urban populations can be lower. For example, according to the NFHS-4 report for Maharashtra, the proportion of women who sought skilled prenatal care was 93% in urban areas and 90% in rural areas, and for health facility deliveries, 95% and 87%, respectively (International Institute for Population Sciences, 2016).

#### **3.5.4 Variations in maternal healthcare-seeking *within* urban areas**

The rural-urban disparities described above suggest a clear urban health care advantage. Indian cities benefit from a more abundant health care sector and a wider supply of public and private providers. Urban women also tend to be better educated, have better access to health information and services, and a more expansive transport system (Das et al., 2016). However, unprecedented growth has led to the urbanisation of poverty and expansion of urban informal settlements (Hazarika, 2010). Patterns of maternal care seeking also vary between sociodemographic groups within urban India. The urban poor have worse indicators of maternal health care (Hazarika, 2010, Prakash and Kumar, 2013). Ghosh-Jerath et al. (2015) found that 21% of women living in urban informal settlements in Delhi did not seek any prenatal care. Another study in three other Delhi informal settlements reported that 53% of women interviewed had delivered at home (Devasenapathy et al., 2014). Hazarika (2010) used NFHS-3 (2005-06) data to test for associations between sociodemographic characteristics and maternal health care utilisation by women aged 15-49 who lived in and outside informal settlements. Although the proportion of women who sought prenatal care was high in both types of area, fewer women in informal settlements made three or more visits compared to those who lived outside informal settlements. A lower proportion also delivered with a skilled person present, with slightly more choosing to give birth at home. Primary research in informal settlements across six municipal wards in Mumbai found that 93% made at least one prenatal visit to a health care provider and that only 16% chose to have a home birth, although the proportion of home deliveries varied between wards (Das et al., 2010). The results of these studies indicate diverse patterns of maternal health care utilisation in urban settlements between and within major Indian cities.

One study found that, among urban women living in informal settlements who sought services, 45% chose private sector providers for prenatal care (Hazarika,

2010). Two studies in informal settlements in Delhi both reported that around 75% of women sought prenatal care from government hospitals or peripheral health posts (Agarwal et al., 2007, Ghosh-Jerath et al., 2015). In a study of maternal care-seeking across 48 of Mumbai's informal settlements, the public-private split was 50:50 among women who had institutional prenatal and 60:40 for delivery care (Shah More et al., 2009a). Most women remained in the same sector from initial prenatal care to delivery, of whom 47% remained in the public sector and 33% in the private sector. Some cross-sector movement did occur from prenatal to delivery care, mostly away from small private clinics and individual providers where childbirth services are unavailable. Migrant women appear more likely to choose inexpensive public sector services than long-term residents. One study found that around 70% of recent and settled migrants sought prenatal care at government health facilities (Kusuma et al., 2013). Similarly, public sector utilization among migrant women living in Mumbai was 59% for prenatal care and 64% for delivery care (Gawde et al., 2016).

### **3.5.5 Individual, household, and broader structural determinants of maternal health care-seeking**

Multivariate analyses reveal the effects of individual, household, community, and other determinants on patterns of maternal health care utilisation. Common individual and household determinants include women's economic status and education, maternal age, parity, caste, religion, and exposure to health-related information through mass media. Community-level determinants include rural-urban location, community deprivation, and access to health care facilities. In rural and urban India, education and individual or household wealth are the commonest and strongest individual predictors of maternal health care use (Das et al., 2016, Mohanty, 2012, Yadav and Kesarwani, 2015). Educated women are likely to have an awareness of health and the value of seeking care, greater autonomy or agency, and ability to make decisions regarding their health care (Arokiasamy and Pradhan, 2013). However, the correlation between education and health agency is not necessarily a direct one (Unnithan-Kumar, 2003). Singh and colleagues' (2012) analysis of NFHS-3 data found that married adolescent rural women with higher education were twice as likely to receive full prenatal care as uneducated adolescents, and almost four times as likely to seek safe delivery care. Similarly, Jat and colleagues' (2011) analysis of DLHS-3 data in Madhya Pradesh found that

women with higher secondary education and above were two-and-a-half times as likely to receive any prenatal care as illiterate women. Since husbands play a central role in household decisions, their educational attainment has also been associated with women's maternal health care-seeking behaviour (Arokiasamy and Pradhan, 2013, Jat et al., 2011, Singh et al., 2014b).

Yadav and Kesarwani (2015) found that women from the richest wealth quintile across India were almost four times more likely to receive full prenatal care than women from the poorest quintile. Pathak and colleagues (2010) reported that more than 80% of poor mothers in rural and urban settings delivered at home without medical assistance compared with non-poor mothers. Studies in Maharashtra state and Mumbai's informal settlements have also shown that women from higher socio-economic groups have fewer home births in favour of facility-based delivery (Das et al., 2010, Thind et al., 2008). In Madhya Pradesh, women from the highest wealth quintile were four-and-a-half times as likely as the poorest quintile to have any prenatal care, and twice as likely to deliver with a skilled birth attendant (Jat et al., 2011). In rural Jharkhand, women in the highest wealth quintile were more than six times as likely to deliver with skilled medical assistance than those in the poorest quintile (Kumar and Gupta, 2016). In rural areas, even when access to health facilities is difficult, household wealth can be a stronger indicator of institutional delivery than distance (Kesterton et al., 2010), emphasising the centrality of economic resources to health care decision-making.

Age and parity appear to influence maternal health care-seeking in different ways. Studies in rural and urban India have generally shown that young women and those who are married early or have their first birth at a young age are less likely to seek prenatal and delivery care than older women (Kumar and Gupta, 2016, Sridharan et al., 2017, Yadav and Kesarwani, 2015). The same trend occurs in urban informal settlements, where older women are less likely to have a home birth (Das et al., 2010) and more likely to receive skilled delivery care (Hazarika, 2010). Birth order seems to have an opposing effect. Higher parity women tend to have a lower probability of receiving institutional maternity care and greater odds of home birth than primiparous women (Das et al., 2010, Ghosh-Jerath et al., 2015, Hazarika, 2010, Singh et al., 2012, Yadav and Kesarwani, 2015). Higher parity might translate into a

lower perceived need for maternal health services, or lead to cultural and economic constraints (Arokiasamy and Pradhan, 2013). For example, women who live in households with more children tend to have considerable responsibility and workload, which can reduce their opportunities to seek care.

Women from scheduled castes and tribes commonly report lower use of maternal health services than women from higher castes (Kumar and Singh, 2016, Sridharan et al., 2017, Yadav and Kesarwani, 2015). Saroha and colleagues' (2008) study of Hindu women in rural Uttar Pradesh found that the use of prenatal and delivery care was significantly lower among women from lower castes compared to those from upper castes. Despite using an oversimplified classification of caste (low caste was defined as "scheduled caste, backward caste, and other backward caste" and everything else "upper caste") and excluding non-Hindu women, the study did suggest that an aversion to intimate contact between people from different castes could deter lower caste women from visiting practitioners from higher castes. Scheduled castes and tribes are among the most socio-economically deprived groups in India, are mostly rural, and commonly marry and commence childbearing at an early age. It is their relative disadvantage across the spectrum of social determinants that accounts for their lower use of institutional maternity care (Kumar and Singh, 2016).

Individual and household determinants are also associated with the choice of maternity care provider. Private sector delivery care tends to increase with wealth and education. In rural India as a whole, half of all women in the least poor households sought delivery care at a private health facility, while less than a third did so from the poorest households (Kesterton et al., 2010). In rural and urban Maharashtra state, increasing maternal education, non-scheduled caste or tribe, and exposure to mass media were associated with private sector over public sector delivery care (Thind et al., 2008). Although increasing wealth and education were associated with greater odds of private sector delivery in Mumbai's urban informal settlements, the opposite was true among tribal communities in rural Jharkhand and Odisha (Das et al., 2016). While families who can afford it are likely to prefer to seek health care at better quality private institutions, low-income families in poorer states and districts may choose public sector care either because they have easier access to

health facilities or because they are motivated by the financial benefits of incentivised public health programmes. Maternal characteristics such as primiparity also appear to influence preference for private sector maternity care (Pomeroy et al., 2014), although maternal age is a potential confounder, since younger women with fewer children are considered more vulnerable, increasing the perceived need for higher quality care with a private provider.

Although individual and household characteristics are strong predictors of maternity health care, they are unable to fully explain care-seeking patterns. A relatively small number of studies have identified community-level and health system variables associated with service uptake, including rural-urban location, the concentration of wealth and education (Yadav and Kesarwani, 2015), coverage of health services (Kumar et al., 2013), access to a health facility, presence and activities of health workers (Singh et al., 2012), and costs of care (Kesterton et al., 2010, Skordis-Worrall et al., 2011, Vidler et al., 2016). Sections 1.5.2 and 1.5.3 described the differential effects of regional and rural and urban location on maternal health care utilisation. Ghosh (2011), found that district-level poverty, measured as a composite indicator comprising household supply of electricity, drinking water, and toilet access, had a significant effect on maternal health care utilisation. Composite indices of structural determinants also indicate that, rather than having an individual effect, poor socio-economic status and environmental conditions can have a cumulative effect on health care-seeking (Awasthi et al., 2016, Ghosh, 2011).

Part of the increase in institutional health care use in India may reflect a decline in use of traditional birth assistants (“*dais*”) and the introduction of Government health programmes such as the National Rural Health Mission (Planning Commission, 2011), as well as the more recently implemented National Urban Health Mission (Ministry of Health and Family Welfare, 2013b). Access to government financial assistance schemes such as the JSY has led to increased public sector maternity care (Powell-Jackson et al., 2015, Thakur et al., 2017). However, assessments of the JSY have been mixed. Evidence suggests that the scheme has successfully contributed to an overall increase in institutional deliveries and has ensured medical and financial benefits for many women living in poor socio-economic conditions since its introduction. One study found no effect on prenatal care uptake, but some effect on



institutional delivery and delivery with a skilled health worker (Powell-Jackson et al., 2015). The study also noted that more women who received JSY benefits tended to deliver in lower-level public hospitals and health centres rather than in private facilities, suggesting that participation in JSY might influence women's choice of health care provider. Other research has reported significant increases in institutional prenatal and delivery care among rural and urban women from lower socio-economic groups (Lim et al., 2010, Randive et al., 2013) . Although the scheme is intended to benefit women from the poorest socio-economic groups, implementation and distribution of financial incentives has been inequitable. Some assessments have found that, although women from all socio-economic backgrounds have benefited from the JSY, institutional delivery in the two poorest states has been lower among poorer, lower caste, and Muslim women (GfK MODE and Development Research Services, 2009, Thongkong et al., 2017). Lim et al. (2010) also reported substantial variations in receipt of JSY and inequitable payment across socio-economic groups, whereby some of the poorest and least educated women had not received the same incentives as other women.

Evidence of the effect of JSY on perinatal and neonatal deaths is inconclusive. Lim and colleagues (2010) reported a significant reduction in perinatal and neonatal deaths associated with JSY, but no effect on maternal mortality. However, two other studies found no associations between increased institutional delivery and reductions in neonatal mortality (Powell-Jackson et al., 2015) or maternal mortality rates (Randive et al., 2013). A before-after study of deliveries at a tertiary hospital in Madhya Pradesh noted an increase in maternal deaths among rural women, but a decrease among urban women (Gupta et al., 2012). The authors suggested that the difference might be due to the relatively higher number of rural women with pregnancy-related complications who were motivated by the JSY to seek care.

Increasing maternity care utilisation has not translated into reduced maternal and neonatal mortality, suggesting the need to expand the reach and impact of health services. In this respect, Rai and Singh (2012) propose a reorientation of maternal health programmes from delivery incentive schemes to practices that prioritise mothers' needs over standard health care practices, such as automatic discharge within 48 hours of delivery, and integrated services that promote women's health

from adolescence to motherhood including preventing intimate partner violence, support with mental health, family planning, and nutrition, as well as ensuring high quality prenatal, delivery, and postnatal care.

The existence of health programmes and incentive schemes has not automatically led to uptake. Interaction between pregnant women and health programme personnel can influence health care behaviour. For example, respondents in one of the few qualitative studies to examine the JSY reported that the ASHAs' role in encouraging institutional maternity care and generating awareness of the scheme, supporting with transport arrangements, and accompanying women to healthcare facilities enabled uptake of care more than financial incentives (Vellakkal et al., 2017). Sunil et al. (2006) analysed NFHS-3 data for the effect of individual characteristics and a series of health programme variables on a composite maternal health care utilisation variable comprising adequate prenatal care, receipt of iron and folic acid for more than 3 months, receipt of two tetanus toxoid injections, institutional delivery, and attendance by a trained health worker. Beside the positive effect of education, non-Muslim faith, non-scheduled tribe, higher living standards, and exposure to mass media, the study found that mothers were more likely to have high utilisation of maternal health care if they were visited by a health worker, had good access to transport, received information, education, and communication (IEC) activities in the last year, availability of a health professional in the village, a public and a private health care facility, a women's group, and an Integrated Child Development Services centre (*Anganwadi centre*). Although the study enables an understanding of "complete" maternity care utilisation beyond individual determinants, it fails to identify the underutilisation of individual maternity care components: for example, women who had adequate prenatal care but chose not to give birth in a health facility. Thakur et al. (2017) have also argued that receiving advice from health workers involved in maternal health incentive schemes might influence some women to choose public over private health care facilities.

Gender inequities and the low status of women play an important role in determining maternal health care utilisation. Namasivayam et al. (2012) found that women who were married at aged 19 or younger and were less educated than their partners were less likely to have prenatal care and institutional delivery. Women with low cultural

capital and weak health literacy can find it difficult to utilise a health system in which they are at risk of exploitation or abuse (Michielsen et al., 2011). Conversely, aspects of women's autonomy, agency, and empowerment can promote greater knowledge of health services, decision-making, and freedom of movement. Studies concur that various dimensions of autonomy can be important determinants of maternal care-seeking in India (Bloom et al., 2001, Matthews et al., 2003, Yadav and Kesarwani, 2015). Women may lack the autonomy to make some decisions, which are often made by husbands and mothers-in-law, although this might now be changing (Vidler et al., 2016). The NFHS-4 census reveals that less than two-thirds of Indian married women participate in decisions about their own health care (International Institute for Population Sciences and ICF, 2017). If family members, such as older women who might have commonly given birth at home, do not perceive the benefits of comparatively costly institutional care, they might be more likely to encourage home births. Unfortunately, because research on autonomy tends to employ different indices, studies on the composite effect of autonomy indicators on care-seeking are often inconclusive. Furthermore, the Western concept of 'autonomy' can be problematic when applied to health-seeking behaviour because its meaning is subjective, not easily interpreted across cultures, and can have negative connotations (Jeffrey and Jeffery 1997, in Matthews et al., 2005).

In this chapter, I have described the epidemiology of maternal and perinatal health globally and in India, described current global and Indian recommendations for maternity care, and reviewed the major patterns and determinants of maternal health and health care-seeking in India. The broad picture gives the impression of a coexistence of progress and inequality. Although the proportion of women in India who choose institutional health care has increased, there are widespread and persistent inequalities in access and utilisation across a range of demographic, socio-economic, and cultural indicators. Social structural and economic conditions vary across and within regions and place of residence, and have a profound influence on service utilisation. These structural inequalities manifest as socio-economic disparities in the availability, affordability, and utilisation of health care. Poverty and other socio-economic characteristics are clearly important determinants of inequity in maternal health in India, since they strongly influence access and utilisation of health services for women from disadvantaged groups (Saxena et al., 2013).

Most of the major reviews of patterns and determinants of maternal health care utilisation have used various rounds of large samples of representative data from national censuses. While they provide access to nationally representative datasets, which can usually be compared with previous data, they are limited in their ability to understand practices and behaviour in specific locations or populations such as marginalised or excluded groups. They are also unable to explain how socio-economic inequalities actually interact with care-seeking mechanisms to produce inequalities in utilisation and health outcomes.

Probably because of the relatively high mortality rates, the focus of population and health care research has been on rural settings; relatively less work exists on patterns of service coverage and utilisation in urban settings. Given the number of rapidly expanding towns and cities in India, population health in urban areas has become an important area of focus. There is a need for further research – particularly qualitative – to understand the influence of social determinants on access to and use of maternal health care in specific settings and communities (Sanneving et al., 2013). Social determinants such as education, wealth status, caste, place of residence, and gender norms act to stratify society and lead to structural inequalities in access to and utilisation of maternal health care services among disadvantaged groups.

Indian towns and cities have a more expansive health sector and a greater concentration and diversity in types of health care provider. However, as with service uptake, patterns of choice between public and private providers are inequitable, with private sector utilisation more common among women from higher socio-economic groups. Although the public sector is an important provider of health care to the poor, a significant proportion of people in deprived neighbourhoods use the private sector. That some women from socially and economically deprived groups also choose and are able to seek maternity care with a private provider is intriguing. Therefore, understanding how individuals and families make decisions about their health care and how they choose particular providers is important. Exploring attitudes to and choice between a range of health care alternatives is necessary to understand the constraints that influence healthcare utilization (Alvesson et al., 2013). Furthermore, understanding and documenting people's health-seeking

behaviours is a pre-requisite to designing strategies and interventions that effectively benefit marginalised groups (Garro, 1998, Grundy and Annear, 2010).

In the following chapter I explore the contribution of the social sciences to advancing a theoretical understanding of health-seeking behaviour, before introducing my own contribution.

## **Chapter 4 Health-seeking behaviour**

This chapter is the result of a comprehensive review of health-seeking behaviour theories from social psychology, sociology, and anthropology. The review revealed the multi-dimensional nature of health-related behaviour and the need to unpack the complex cognitive, social, economic, and cultural factors and processes that underlie health-seeking decisions. It also led me to seek further insight from fundamental sociological ‘theories of practice’ on the nature and relationship between structure and agency, and the social processes through which health-seeking is socially produced and reproduced.

The chapter explores health-seeking behaviour as a specific field of research and examines theoretical contributions from across the social sciences. I begin by introducing the conceptual perspectives of social psychology, sociology, and anthropology. An overview of all three disciplinary perspectives is, I believe, important because of the multidimensional nature of health-seeking decisions and practices. I then outline three sociological models of health-seeking and examine relevant contributions from medical anthropology. An assessment of the strengths and limitations of these approaches makes clear the need for further research, provides the rationale for my choice of methods, and lays the foundation for the presentation of the study findings. The next section summarises debates on the interrelationship between social structure and individual agency. I introduce the concept of structuration and briefly compare the perspectives of two prominent social theorists, Anthony Giddens and Pierre Bourdieu. In the final section, I synthesize recent qualitative and anthropological studies on relevant aspects of reproductive and maternal health care-seeking in India.

### **4.1 Understanding health-seeking behaviour**

Health behaviour involves a complex interaction of cognitive, cultural, and structural factors. It is an academic specialisation in several social science disciplines, including social psychology, medical sociology, and medical anthropology. Although there is overlap across disciplines, broadly speaking, social psychologists have emphasised the major cognitive behavioural determinants (e.g. Ajzen, 1991,

Rosenstock, 1974) and medical sociologists the social determinants of health and processes of health-seeking (e.g. Aday and Andersen, 1974, Igun, 1979, Suchman, 1965). Medical anthropologists have produced in-depth, descriptive studies of complete medical systems (e.g. Fabrega and Silver, 1973, Janzen, 1978) and local, cultural constructions of health, illness, and health-seeking behaviour (e.g. Hausmann-Muela et al., 1998, Molina, 1997, Weiss, 1988). These approaches all differ from each other in their disciplinary focus, units of behaviour, methods, and analysis.

The influence of the social environment on health and well-being is now widely accepted. Our understanding of the determinants of health has moved beyond biomedical models based on positivism, and there is a growing recognition that identifying causes of ill health requires a multidimensional approach that incorporates social and environmental factors (Taylor and Field, 2007). Socio-medical approaches provide a range of critical theoretical perspectives on the complex relationship between individual experiences of illness and health care and the wider social structures and institutions within which they occur (Bradby, 2012, Taylor and Field, 2007). Structural conditions and individual agency are both key factors that influence health in complex ways (Abel and Frohlich, 2012, Williams, 2003). As a fundamentally social action, health-seeking is also a process through which human agents relate to social structures. Therefore, a key consideration for understanding health-seeking behaviour is whether the decisions people take are predominantly the result of individual agency or the social structures in which action takes place, or an interaction between the two. Social practice theorists have sought to move beyond models that emphasise either the role of the individual in behaviour or the social structural context in which behaviour occurs (Blue et al., 2016, Cohn, 2014). Drawing on the work of Giddens (1984, 1993), Bourdieu (1977), and others, these theories treat ‘health practices’ as the unit of analysis and human agents the participants or “carriers” of the practice (Reckwitz, 2002).

## **4.2 Models of health-seeking behaviour**

Research into how people make decisions about their health and what determines their health behaviour began several decades ago (Glanz et al., 2008). Kasl and Cobb (1966) summarised this research through a typology of three main health-related

behaviours: health behaviour, illness behaviour, and sick-role behaviour. Health behaviour refers to the activities that asymptomatic people carry out to protect their health. Illness behaviour is carried out by people who feel ill and seek to identify a suitable treatment. Sick-role behaviour – a concept developed by Talcott Parsons (Parsons, 1975) – is an “activity for the purpose of getting well, by those who consider themselves ill. It includes receiving treatment from appropriate therapists, generally involves a whole range of dependent behaviours, and leads to some degree of neglect of one’s usual duties” (Kasl and Cobb, 1966: 531).

According to this typology, it is reasonable to classify maternity care during an uncomplicated pregnancy as health behaviour that is primarily motivated by a desire to prevent complication during pregnancy and delivery and protect the unborn infant. In the event of a complication, a pregnant woman would likely adopt the sick role. To the extent that a woman giving birth under the supervision of a health professional or practitioner, whether this is a doctor, midwife or traditional birth attendant, is undergoing a form of specialist health care treatment, and her condition excuses from her usual activities, childbirth shares some of the characteristics of the sick role. However, pregnancy and childbirth are conceptually distinct from sickness and disease. In contrast to sickness, pregnancy is a condition necessary for human survival and, when planned, is generally a desirable occurrence. In addition, normal pregnancy does not typically involve illness symptoms or obstetric complication. This can have important implications for women’s health behaviour and is likely to influence their motivation to seek health care, choice of provider, and expectations of care-seeking encounters. The presence or absence of symptoms is also important in defining conditions for exemption from routine social roles. Furthermore, women’s social position influences their maternal health status and associated role fulfilment. For example, women with higher social status and agency might have the ability to influence their structural environment to access beneficial aspects of the sick role, such as exemption from social roles and obligations, and recourse to professional medical care (McKinlay, 1972).

An enormous body of theoretical and empirical work on health behaviour and health care utilisation now exists and has led to the development of increasingly complex models of health-seeking behaviour (Hausmann-Muela et al., 2003). Most models



attempt to explain or predict behaviour by identifying a range of individual or health-related variables and showing their associations with the adoption of, or resistance to, the performance of given behaviours. This requires a clear understanding of the causes and conditions in which specific health behaviours take place (Hausmann-Muela et al., 2003, Rosenstock, 2005). Models are often categorised as either determinants or pathways models (Mackian et al., 2004). Determinants models seek to identify a set of explanatory variables which are associated with the choice of different types of health service (Kroeger, 1983). They usually involve the use of statistical methods to test for associations between key variables and behavioural outcomes. Determinants models use explanatory variables that reflect different levels of analysis, although they typically include individual, community, and health service levels. Pathways models recognise that health- and illness-related behaviours are part of a process in which a healthy person becomes a patient (Mackian et al., 2004, Zola, 1973). Individuals move through a series of stages or phases and interact with other individuals as well as the events they experience. The nature of these interactions varies at each stage but can affect the likelihood and type of subsequent response the individual makes (Rosenstock, 1974). Pathways to health care are complex, and models need to include both the different types of health care provider as well as those they reject (Alvesson et al., 2013: 11). Determinants and pathways models differ in their approach to health- and health-seeking behaviour, although they are not necessarily mutually exclusive. For example, individual socio-economic characteristics can influence a person's predisposition to a particular health condition and subsequently how he or she interprets and responds to it. Researchers tend to favour one approach over the other, usually because of their disciplinary background, although some cross-disciplinary research has combined both.

#### **4.2.1 Social cognitive models**

Social psychologists commonly use a determinants approach in a number of social cognitive models (SCMs) to describe a variety of cognitive determinants of health behaviour (Armitage and Conner, 2000). Cognition refers to psychological processes that mediate observable stimuli and behaviour, and health cognitions are perceptions and beliefs concerning health-related behaviour (Conner, 2010). Social cognition extends these concepts beyond individual psychology to the social contexts that

inform perceptions and beliefs which, in turn, influence decision-making and behaviour.

Popular social cognitive models include the health belief model, the theory of reasoned action and the theory of planned behaviour, and the integrated behavioural model. The health belief model has been used widely to explain a variety of health behaviours, including the acceptance or avoidance of medical advice and of health care services (Rosenstock, 1974, Rosenstock, 2005, Rosenstock et al., 1988), and responses to illness symptoms (Janz and Becker, 1984, Rimer, 2008). The theory of reasoned action and theory of planned behaviour propose that a person's attitudes towards a behaviour and normative social expectations towards it determine their intention to act. For intention to become action depends on the degree to which the person perceives his or her ability to carry it out, known as behavioural control (Ajzen, 1985, Ajzen, 1991). The integrated behavioural model includes concepts from various social cognition theories. It proposes that a person is most likely to perform a behaviour when they have the intention to act, the knowledge and skills to do it, face few environmental barriers (e.g. distance to a health facility), have previous experience of performing it, and if the behaviour is salient or triggered (Montaño and Kasprzyk, 2008). Many more social-psychological models exist but, given its sociological orientation, are outside the scope of this thesis. Inclusion of the models described above is intended as recognition of the contribution of social cognitive models to the health-seeking field and to outline some relevant concepts.

A common feature of SCMs is the idea of motivation as driver of behaviour. Motivational models often use intention as the dependent variable most closely related to behaviour on the assumption that behavioural performance is more likely when intention is high. However, motivation in itself is not necessarily sufficient for action and these models do not fully explain how motivation results in the performance of a particular behaviour. For example, the influence of material capital and social structure on health behaviour must not be overlooked (Hausmann-Muela et al., 2003). Importantly, most models have been applied primarily in high-income country contexts; much less research has been done in middle- and low-income countries. These limitations create a space for social theories to explore the interplay

between material and social structures and health behaviour in resource-poor settings.

#### **4.2.2 Sociological models**

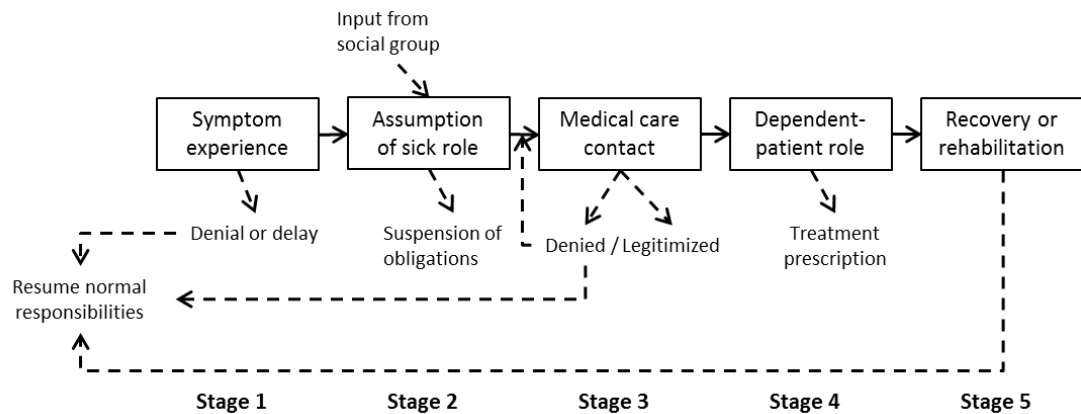
Sociological models of health-seeking behaviour tend to emphasise the contextual, social, and medical events and actions related to health and illness. Typical events include the social behaviour of health care consumers and providers, the social function of health institutions and organizations, and the relationship between health care systems and other social systems (Sigdel, 2013). Both determinants and pathways approaches are commonly used to develop these models, although they differ in their objectives. Of the determinants models, Andersen's behavioural model of health service use is probably the best known (Andersen, 1995) (see 1.2.2.3). Kroeger (1983) (see 1.2.3) developed a model that combined socio-medical and anthropological determinants of health care use in low-income countries. Many sociological models use a pathways framework and describe phases or stages of health behaviour. Pathways models of health-seeking for illness include Suchman's (1965) five-stage process of illness experience and care-seeking (see 1.2.2.1) and Igun's (1979) eleven-stage model of health-seeking for illness (see 1.2.2.2). Although these models are dated, they continue to provide some commonly-used concepts, and serve as examples of diverse applications and methodologies in sociological health research.

##### ***4.2.2.1 Suchman: five stages of illness and medical care***

Suchman (1965) developed a model of health care-seeking through research with a cross section of adults in an ethnically and socio-economically diverse area in New York. A team of researchers collected information on socio-demographic characteristics and illnesses for which they sought health care. They followed this up by conducting in-depth interviews with more than a thousand of them about their social networks, illness symptoms, health knowledge, attitudes, and behaviour. Figure 4.1 is a simplified visualisation of the model's five stages: symptom experience, assumption of the sick role, medical care contact, dependent-patient role, and recovery or rehabilitation. The movement from one stage to another represents a transition point which involves making new decisions about subsequent actions.

While every stage does not have to be present in an episode of illness, Suchman argues that most, in some form, usually are.

**Figure 4.1. Suchman's five stages of illness and medical care**



(Source: Suchman, 1965)

- (1) **Symptom-experience.** People assess whether anything is wrong with them through the experience of symptoms. These can be physical, cognitive, or emotional (e.g. fear or anxiety). The decision to seek health care requires recognising symptoms as indicative of an illness, assessing their seriousness, and the effect they have on the person's normal social functioning. In some cases, denial of illness may occur, leading to delayed or non-use of health care.
- (2) **Assumption of the sick role.** The individual, together with his or her proximate social group, takes the decision that he or she is sick and in need of medical care (lay referral). This might involve seeking information and advice from the group about the symptoms and what to do. It also serves to garner the support necessary to enter the sick role and warrant care-seeking. Suchman found that almost all sick individuals followed advice and recommendations from others.
- (3) **Contact with medical care.** The person seeks a 'scientific' source of medical care (i.e. a biomedical physician) in order to legitimise the illness. Alternatively, the practitioner may instruct the individual to return to normal activities. If the individual does not accept the practitioner's diagnosis or instruction, they may seek an alternative. Suchman hypothesised that the choice of a specific source of care is determined by the individual's and social group's knowledge of

alternatives, and the availability and convenience of available services. The events that take place in the medical encounter play a crucial role in the person's subsequent health-seeking behaviour.

- (4) **Dependent-patient role.** The sick person becomes a 'patient' by transferring control for his or her condition to the physician. In this stage, communication between patient and physician is important because contradictory understandings of illness and medical treatment will hinder the process. Patients who were well-informed reported greater compliance with physician advice.
- (5) **Recovery or rehabilitation.** This stage is when medical treatment ends or the patient withdraws from care. The person transitions back from the sick role to a healthy one through a process of rehabilitation, the timeframe and demands of which vary according to the nature of the illness and treatment.

The model conceptualises health-seeking as a dynamic process in which each stage is influenced by events and outcomes of the previous stage. It incorporates elements of social cognitive, social and cultural influences on health-seeking. Cognitive elements mainly appear in the assessment and response to illness symptoms, although they are not well developed. Suchman's model emphasises the influence that the social group has on defining an individual's status, sanctioning access to, and exit from, the sick role, and shaping health action. It also shows how cultural variation in the understanding and response to illness and symptoms leads to differences in health-seeking behaviour. Importantly, it identifies the role that a person's experience of health encounters plays in future health care decisions.

There is some criticism of Suchman's model. It assumes a unified "scientific" medical system, and therefore fails to explain health-seeking behaviours in settings where people use multiple sources of care or switch between them over the duration of illness. For example, in urban Mumbai, patterns of treatment-seeking for health problems during pregnancy are complex and involve the use of both public and private health sectors, and multiple providers for different types of complication (Shah More et al., 2011). Furthermore, the close ties between Suchman's model and Parson's functionalist sick role also restrict its usefulness to understanding preventive or routine health care such as maternity care-seeking. The model also overlooks much of the complexity of how people choose a provider among

alternatives. As some researchers have pointed out, it is important to take into account different types of care options, including self-care and pharmacies (Harpham and Molyneux, 2001, Igun, 1979).

#### ***4.2.2.2 Igun: eleven stages of health-seeking***

Building on Suchman's work, Igun (1979) identified eleven stages of care-seeking and recovery from illness. Igun's use of symptom-experience mirrors Suchman's, with the addition of a symptomatic 'trigger', which alerts the person to symptoms that indicate potential illness. The model also incorporates self-treatment as an option, depending on the person's understanding of the symptoms. Having entered the sick role, the social group provide social support and help identify suitable sources of care. Treatment is assessed for efficacy throughout the illness experience. As in Suchman's model, the final stage is recovery and rehabilitation.

Both Suchman's and Igun's models outline key stages and events in health-seeking, from the recognition of symptoms to the use of medical care and the return to a state of health. In this they extend previous sociological models of health-seeking. Both models were published several decades ago, but they remain relevant. Although Suchman conducted his study in New York, Igun incorporated his own data from Nigeria. Igun acknowledges the existence of health care pluralism, and therefore allows for explanations of health care-seeking across systems, sectors, and providers. Igun's model can also account for movement across different providers at different times during a period of illness.

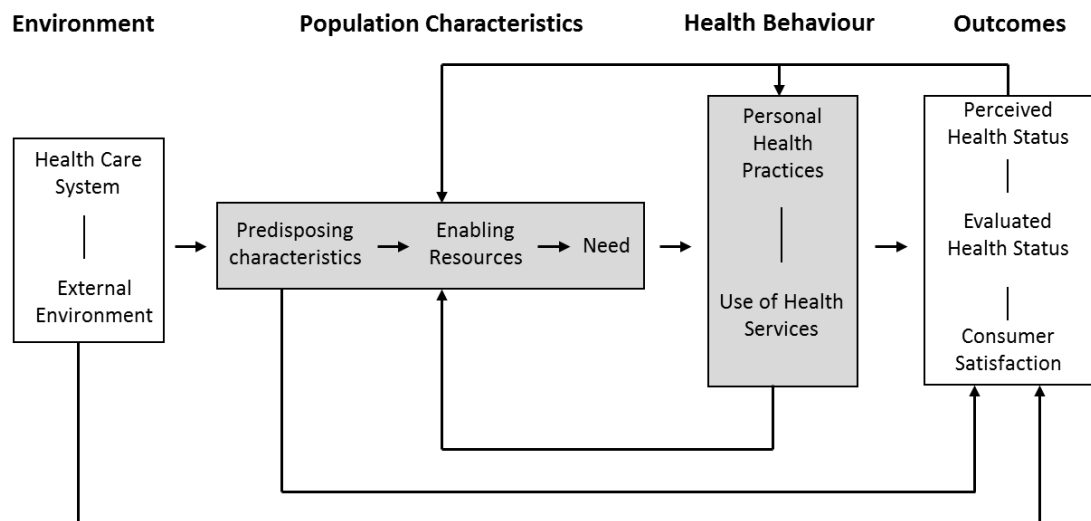
Suchman and Igun designed their models to explain health-seeking for symptomatic illnesses. The models do not appear to have been applied to other health behaviours, including the use of preventive health care. Neither model considers the role of families' socio-economic status on health care-seeking choices, or the process of gaining access to different types of medical care, limiting their ambit of applicability. Although Suchman's model includes a stage concerned with seeking a source of health care, he merely identifies four determinants of choice (knowledge, availability and convenience of the services, and influence of the social group) and does not explain how these concepts operate. While the five-stage model is fairly linear, in

Igun's model the sick person can return to previous stages if medical circumstances change.

#### ***4.2.2.3 Behavioural model of health care utilisation***

Andersen's (1995) behavioural model of health care utilisation (Figure 4.2) explains variations in health service use and the conditions that facilitate or impede it. At the centre of the model is a set of predisposing characteristics that influence perceptions about health and the need to seek care. These include age, sex, and socio-economic indicators. Enabling resources such as the availability and distribution of different types of health service and the means to access them act as key facilitators or barriers to care-seeking. Other enabling factors include social relationships, such as with the care-seeker's family. In addition to predisposing characteristics and enabling resources, the perceived and evaluated (i.e. based on professional judgement) need for care provide the motivation to seek a health service and to comply with treatment. Together, these central population characteristics determine health care use, including personal health practices and the type and amount of care sought. Wider systemic factors include the health care system and physical, political, and economic factors ('external environment') within which health care-seeking takes place. Health behaviours and service use result in perceived and evaluated health outcomes, and satisfaction with services, which influence subsequent predisposing factors, perceived need and health behaviour.

**Figure 4.2. Andersen's behavioural model of healthcare utilisation**



(Source: Andersen, 1995. Shaded areas indicate concepts in the original model)

Since its initial conception in the 1960s, Andersen's model has undergone various improvements and has become one of the most comprehensive frameworks available to understand the multiple influences on both preventive and curative health care use. Additional features included in the final version were the influence of health system factors and that health service use can vary by type, place, time and reason for use. It also incorporates the interaction between variable sets. For example, people of different ages or socio-economic backgrounds might experience different levels of satisfaction with services or health outcomes. These, in turn, can influence subsequent perceived and actual need for care and further use of services. Importantly, inherent in the model is the ability to explain variation in use through determinants related to inequitable access.

The model relies on the assumption that individuals make rational decisions about their health by systematically reviewing available information and forming 'behaviour intentions'. Although Andersen acknowledges the importance of social relationships in facilitating or impeding people's use of health services, the model does not describe the nature of these relationships and merely suggests that they "might fit in nicely as enabling resources" (p. 3). Andersen focuses mainly on trying to explain people's uptake of formal health care. While he acknowledges that incorporating different types of provider and service, including non-formal ones,



would help to understand how and why people use them, he does not include them in the model.

#### **4.2.3 Contributions from medical anthropology**

Health services research tends to favour the social and psychological background to health-seeking behaviour, often overlooking the important role that illness characteristics play in the process of choosing a health care provider (Fabrega and Zucker, 1979). Early anthropological work has focused on understanding illness causation, process and treatment in a cross-cultural context. A common assumption is that people's choice of health care provider reflects a compatibility between their lay beliefs about causes and symptoms of illness and the practices of different types of healer (Young and Garro, 1982). For example, Byron Good's analysis of 'heart distress' in Maragheh, Iran used the term *semantic illness network* to describe "the network of words, situations, symptoms and feelings which are associated with an illness and give it meaning for the sufferer" (Good, 1977: 40). Good showed how illness narratives, their form and content are shaped by the local social context. As he explains, "Heart distress is an image which draws together a network of symbols, situations, motives, feelings and stresses which are rooted in the structural setting in which the people of Maragheh live" (Good, 1977: 40).

Models such as these can help explain how compatibility between medical and lay models of health can influence decisions regarding the use of treatment. The opportunity to encounter complementary or competing explanatory models immediately arises in the transitional space of urban Mumbai. Molina (1997) found that differences in physiological understanding, ideas of personhood, illness and therapy between mixed-ethnicity women and local biomedical practitioners in Argentina led many women to reject modern contraceptive methods. Research in India has also described the influence that local perceptions of the properties and characteristics of both herbal and Western medicines can have on health behaviour and choice of therapy (Nichter, 1980, Nichter and Nichter, 1996). In a study in South India, Nichter explained local people's choice of treatment and medication mainly in terms of 'habituation', power, the overt characteristics of medicines, and dietary advice. Habituation (*'abhiyasa'*) refers to the way the body assimilates, or adjusts to,

the intake of substances such as food and medicine, based on beliefs about the effect the properties of the substances have on the body (e.g. heating or cooling). Local people talked about some medicines “not taking to”, or agreeing with, them, meaning that their bodies could not absorb the medicine and would cause a physiological disturbance (Nichter and Nichter, 1996). It is clear how these beliefs could influence the choice of medical system and provider.

Ethnographic research among a tribe in Lower Zaire found that treatment options were decided through a process of identifying the underlying cause of the condition and appropriate types of treatments and healers (Janzen, 1978). Janzen looked at who takes charge during health crises, noting that decisions were not taken by the individual but by close social groups. He conceptualised the two related ideas of “therapy management” as “the diagnosis, selection, and evaluation of treatment, as well as support of the sufferer”, and “therapy management group” as “the set of individuals who take charge of therapy management with or on behalf of the sufferer” (Janzen, 1987: 68).

Other studies have shown that lay understandings of health and illness do not necessarily act as barriers to using biomedical treatment. Young and Garro (1982) found that the major factor influencing decisions to seek medical treatment in two neighbouring Mexican villages was access to low cost health care (via local resident physicians) rather than conflicting medical beliefs (“conceptual incompatibility”). Although both communities shared a common lay medical belief system that was inconsistent with Western medical practice, physician utilisation rates among villagers with greater access were twice those of the village with limited access. It should be pointed out, however, that in both areas the rate of self-treatment was very high (85% and 69%, respectively). Therefore, while the differences between the two groups were notable, the majority of cases of illness were still managed in the home, suggesting that biomedicine was considered unsuitable for treating most illnesses.

In comparative research on how people transition from person to patient, Zola (1973) found that people’s direct experience of symptoms was not the primary motivation for them to seek care, but how they were socially experienced. He suggested that critical events cause people to seek medical help when they do. These triggers or

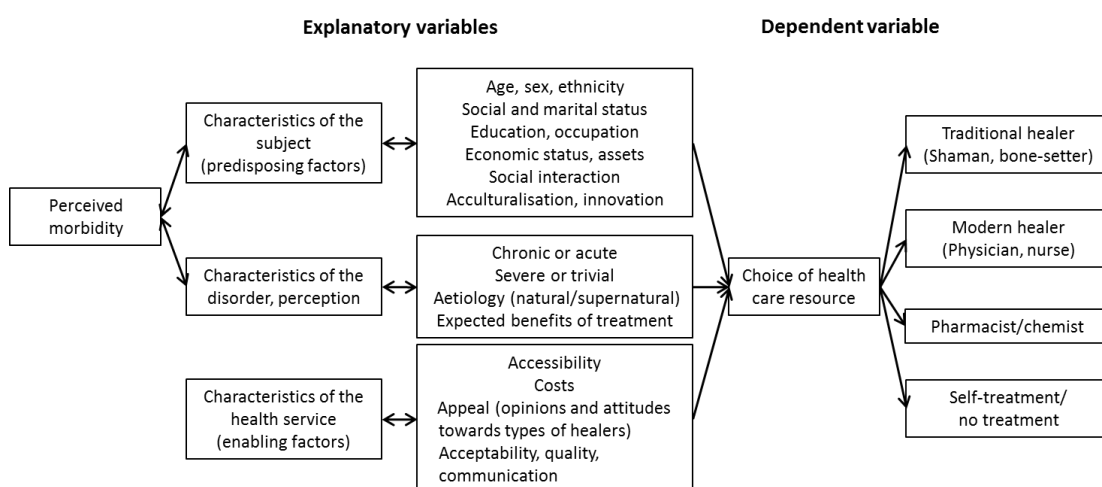
cues to action have been noted in other models described above (for example, Igun, 1979, Rosenstock, 1974). Zola argued that the search for physical relief from illness was only part of the explanation for seeking treatment. Given that some individuals and families delay care-seeking, he hypothesised that they must, to an extent, normalise or accommodate the health condition and that care-seeking is triggered when they are unable to accommodate it, for example, when the impact of symptoms on their social situation and functioning become intolerable. Interestingly, his research involved studying sick people in the process of seeking treatment, but who had not yet experienced health care. However, since it was only conducted in one American general hospital, its relevance to other contexts has not been evaluated.

Kroeger (1983) reviewed socio-medical and anthropological literature on health care use for illness in low-income countries, and developed an integrated framework using three sets of determinants: characteristics of the subject, the disorder, and the health service (see Figure 4.3). Characteristics of the subject were individual predisposing factors, similar to those identified by Andersen (1995). Characteristics of the disorder identified differences in choice of treatment method according to whether the illness was chronic or acute, severe or trivial. Lay understanding of disease aetiology and type of health problem had an important influence on choice of provider although, since these are culturally constructed, the actual choice varied across studies. Studies reported that expected benefits and satisfaction with provider treatment also influenced choice, generally towards modern sources of care. Again, similar to Andersen's model of health care utilisation, characteristics of the health service were enabling factors and included physical access, the appeal and acceptability of patient-provider communication, quality of care, and costs.

Kroeger showed that concepts from across disciplines offer a more comprehensive understanding of health service use. The review included studies from a range of rural and urban settings, although it insufficiently explored how different conditions and settings influence health care choices. The relative diversity of towns and cities, as well as particular characteristics such as the availability of providers and shorter distances, was under-considered. A major limitation was the dual categorisation of healing systems into 'traditional' and 'modern'; this reductionist dualism ignores the complexity of urban health care systems. Kroeger did recognise the common practice

of simultaneously using different types of provider during the same illness episode, but the empirical evidence rarely details particular practices such as provider shopping or switching from one to another after a poor experience of care. These reflect the limitations of most determinants models and are particularly relevant to maternity care-seeking in contexts with pluralistic health care systems and practices such as urban Mumbai.

**Figure 4.3. Kroeger's explanatory variables and choice of healer**



(Adapted from Kroeger, 1983)

Early studies in medical anthropology have been criticised for over-emphasising cultural phenomena (symbols, rituals, values, beliefs) as the major determinants of health and health-related behaviour, and the failure to take into account national and global social, historical, political, and economic structures and functioning. These play a central role in creating the conditions that influence people's exposure to health risks, as well as their health care options and access to treatment (Joralemon, 2016). This 'political economy of health' has been called the "missing link" in conventional medical anthropology (Morsy, 1979).

The political-economic perspective also has a gendered dimension. Women's ability to reproduce creates a special set of health needs which require specific health services (e.g. maternity care). However, global political-economic restructuring, such as the structural adjustment policies of the 1980s and early 1990s, have

disproportionately affected women's ability to meet health needs. For example, increased health care costs, combined with the low priority given to reproductive health care in many countries, have made it increasingly difficult for many women to access health care (Doyal, 2004).

These limitations and conditions have resulted in the emergence of a critical medical anthropology (CMA). Largely influenced by Marxist theory, CMA understands health and health behaviour in terms of the global political and economic forces "that pattern interpersonal relationships, shape social behaviour, generate social meanings, and condition collective experience" (Singer, 1990: 181). Explicit in the CMA perspective is an understanding that many health problems are a product of socially-produced conditions such as poverty or class discrimination, rather than natural or biological circumstances.

CMA seeks explanations for illness and health care at individual, micro- and macro-social levels by asking why unequal structural conditions prevail, who benefits and who suffers as a result, and how poor health differentially affects different socio-economic groups (Joralemon, 2016). The multilevel approach is important because it allows for the idea that people's health and health care decisions are influenced by both local social and cultural constructions (e.g. beliefs and values) and wider political-economic forces. Singer (1990) has argued that, "research must be directed at clarifying the manner, form and degree to which macroprocesses are manifested at the microlevel" (182).

### **4.3 Assessing health-seeking behaviour models**

This review is limited to a small number of social science models. However, it should serve to demonstrate the array of approaches and diversity of concepts across disciplines to explain how people make sense of and respond to health and illness. The result suggests a hierarchy that is loosely based on the extent to which each one captures a broader or narrower set of explanatory concepts.

Cognitive models identify a range of psychological determinants of health behaviour, but tend to overlook the processes of choice and adoption. Furthermore, models have largely been developed in high-income settings and, therefore, might have limited

capacity to explain health-seeking behaviour in contexts with distinctive forms of social and cultural organisation. Socio-medical models that focus on health service factors such as accessibility, costs, and acceptability, as well as an anthropological focus on lay beliefs about the origins and causes of illness, represent a polarity of approaches (Kroeger, 1983). The result is a detailed but fragmented picture that lacks constructive engagement across academic disciplines. This limits not only their explanatory capacity, but also their usefulness for policy makers and program planners to design and implement effective health interventions in ways to maximise improvements in population health. A problem with determinants analyses that test for correlations of selected variables with reported utilisation of health care is that health-seeking behaviour cannot be understood by reducing it to isolated factors, but should be understood as a progression of unfolding events associated with health-seeking (Igun, 1979).

Although elements of each of the different models outlined above might help explain patterns of maternal health care-seeking in urban areas of low- and middle-income countries, none of them provides a sufficiently comprehensive set of concepts. Most models only offer partial explanations for patterns of health behaviour. Integrated models, combining individual cognitive and broader social structural concepts might provide more comprehensive explanatory accounts. Despite the potential benefits, few have attempted this. One notable exception is Andersen (Aday and Andersen, 1974, Andersen, 1995), whose behavioural model of health care includes variables related to social psychology, access to social and economic resources, and characteristics of the health system.

Despite their complexity, models often emphasize either individual psychosocial determinants of health behaviour (e.g. the health belief model) or the socio-economic and structural conditions within which health-seeking take place (Williams, 1995). Concepts that represent individual determinants of health-related behaviour often compete with those relating to social and health system structures. These models fail to explain how individual agency and social structures interact in the production of health-seeking behaviour, and inadvertently reproduce the old agency-structure dichotomy. In this respect, drawing on relevant, fundamental sociological theory,

such as structuration, would allow a re-examination of health-seeking behaviour in light of contemporary discussions of structure and agency.

#### **4.4 Social structure and individual agency**

A critical debate in sociology has centred on questions about the precise relationship between individual action and the structural features of the social world to which actors belong (Thompson, 1989). Structural theories propose the existence of an objective social reality, with established networks of social institutions and durable social relationships. Few dispute the idea that social structure shapes the circumstances in which people find themselves and the actions they choose to perform (Williams, 2003). It is this structure that results in patterned, socially reproduced behaviour (Bilton et al., 1987, Taylor and Field, 2007). While the ‘structuralist’ approach emphasises the influence of social structures on action, an ‘individualist’ approach emphasises the role of human agency in shaping social structures (Collyer et al., 2015). Despite the efforts of structuralists and functionalists to explain social action from both perspectives, there is no consensus on the independent or interrelated effects of structure and agency on action. The resulting ontological and epistemological tensions oppose conceptions of social structure as an ‘external’ system that operates independently of agents and constrains action on the one hand, and action as a creative force through which agents construct the social conditions in which they act on the other.

##### **4.4.1 Structure, agency, and health**

The structure/agency debate is relevant to understanding the relative roles of individual agency and social structure in shaping health (Cockerham, 2013). The sociocultural environment plays a crucial role in the formation of health beliefs and practices, including maternity. This, in turn, influences the status of maternal health and related health care-seeking practices (Warren, 2010). A “structured disadvantage” perspective emphasises the effect of difficult or unequal social, political, and economic conditions on opportunities for health and health-seeking. Local social and cultural inequalities, including poverty, caste, class and medical control influence the way in which poor women construct their identities, make health choices, and experience services (Unnithan-Kumar, 2003). Researchers who see health as a function of a social structure that allocates resources unequally

sometimes criticize the idea that health is primarily determined by individual agency and behaviour (Knowles 1977). From this perspective, social structure is understood to restrict health chances. Rieker and colleagues' (2008, 2010) model of 'constrained choices' describes the cumulative impact of structural constraints on differential exposure to stressors, health behaviour, and psychological and physical health. For example, competing daily demands on women's time and energy can have a constraining effect on their health decisions and ability to access health care. The constrained choice model offers insights into the multiple pathways through which social structures impact health and health-related behaviour. However, social structure is not uniformly experienced by everyone, and can be both constraining and enabling (Giddens, 1984, Ortner, 2006). Although social, cultural, political, and economic structures can restrict women's health-seeking decisions, those with higher status (for example, those with more formal education) can exercise greater agency than other women, affording them a wider set of choices (Raman, 2014). Importantly, the constrained choice model does not explain the process by which individuals and groups go about making health-seeking decisions in constrained social structural conditions. This is of importance to India, where economic growth and urbanisation have exacerbated socio-economic inequalities, but where demand for health care remains high. The issue is, perhaps, less about whether social and financial constraints limit women's utilisation of health care – as Jeffery and Jeffery have shown, "The most poverty-stricken and powerless members of Indian society experience deep-seated class, caste and urban prejudices against them in many contexts, including when they seek health care" (Jeffery and Jeffery, 2010a) – than understanding how families act towards their health under constraining social and economic conditions.

An alternative perspective emphasizes people's subjective experiences of health and illness outside, or in conjunction with, the effects of social structure. Individual and group knowledge, beliefs, and attitudes influence perceptions of health and illness, health needs, forms of treatment, and health seeking behaviour. This is relevant to maternity care-seeking, where symptoms may or may not be present. One of the main factors underlying decisions to seek health care is the belief that doing so will benefit the person's health (Thaddeus and Maine, 1994). Since pregnancy and childbirth are constructed as 'natural' states, for women who experience an



uncomplicated pregnancy or anticipate a normal delivery, institutional delivery is sometimes considered unnecessary (Blanchard et al., 2015, Griffiths and Stephenson, 2001, Unnithan-Kumar, 2003). In contrast, when health problems or symptoms of obstetric complication do occur, health-seeking decisions are often influenced by lay interpretations, and the timing and choice of treatment-seeking are related to perceptions of severity (Thaddeus and Maine, 1994). Institutional health care might be perceived as the preferred option for treating serious problems and emergencies (Sudhinaraset et al., 2016). However, although women may seek help for severe or life-threatening conditions, low knowledge of some symptoms can impede treatment-seeking and the selection of a suitably qualified provider (Head et al., 2011, Koenig et al., 2007, Shah More et al., 2011). Therefore, health care decisions are related to perceptions about the level and type of service required, and providers deemed able to deliver it. Moreover, while choosing a suitable provider for routine or basic preventive services such as prenatal care or immunisation might be relatively straightforward, the need for specialist or emergency care can potentially involve a rigorous and problematic process.

Experiences and perceptions of health care also influence demand for services. Among the many dimensions commonly described in the health care literature are distance, cost, and quality of care. Thaddeus and Maine (1994) argued that user satisfaction (or dissatisfaction) with care-seeking outcomes (i.e. the effectiveness of care) and service provision (hospital procedures, staff attitudes, availability of supplies, and efficiency) are primary mechanisms that link perceptions and experiences of quality and care-seeking decisions. Other aspects include structural aspects of health facilities, such as the physical environment and cleanliness (Srivastava et al., 2015). Recent research provides evidence that health literacy, understood as the ability to access and understand health information to maintain or improve health, is associated with greater trust in physicians and the health care system (Tsai et al., 2018).

In low- and middle-income countries, mistreatment of women during institutional childbirth is common. Mistreatment includes physical, sexual, and verbal abuse, stigma and discrimination, substandard care, poor rapport between women and providers, and systemic health facility and health system failures (Bohren et al.,

2015, Mannava et al., 2015). In a systematic review by Srivastava and colleagues (2015), provider interpersonal behaviour was the most widely reported determinant of satisfaction with maternity care, suggesting that women attending health services placed a high value on respectful and dignified treatment. Thaddeus and Maine (1994) noted that perceived quality of care is often given higher priority in health-seeking decisions than distance to a medical facility and cost of services. Certainly, distrust and fear of various forms of mistreatment, which are often related to social status and caste, represent barriers to institutional maternal health care-seeking and are critical reasons why women choose to deliver at home, or avoid a particular health care sector or provider (Sudhinaraset et al., 2016, Unnithan-Kumar, 2003, Van Hollen, 2003).

#### **4.4.2 Theories of practice**

Social theorists have sought to resolve the structure/agency controversy through practice theory. Practice theory views human action as sets of interrelated social 'practices' rather than individual, discrete behaviours that are motivated by intention or that are determined solely by external social structures (Cohn, 2014). Ortner (2006: 16) describes it as "a general theory of the production of social subjects through practice in the world, and of the production of the world itself through practice". In other words, instead of working individually or in competition, structures and agency are interrelated. Practices are routinized behaviours involving interconnected bodily activities, cognitive activities, material objects and resources, and involve complex forms of understanding, emotions, and motivation (Reckwitz, 2002). Agents exist not as rational decision-makers but 'in' the practices they perform, or, as Reckwitz (2002) puts it, are "carriers of the practice", while structures exist only through the performance of social practices (252-5).

As a strand of practice theory, structuration is a theoretical attempt at reconciling the relationship between objective social reality and the human subjective experience of it. Objectivism emphasises subject-less structures and forces which agents act out in the social system. Subjectivism, on the other hand, reduces social life to human agency, which is manifest in individual or group action, interaction, interpretation, and practice (Stones, 2005). Structuration theorists agree about the existence of both structure and agency, and reject the total dominance of one over the other in favour

of an interdependent relationship. However, the nature of this interdependence of objective social structures and subjective human agency is disputed (Parker, 2000). I now briefly examine the theoretical perspectives of two prominent practice theorists, Anthony Giddens and Pierre Bourdieu.

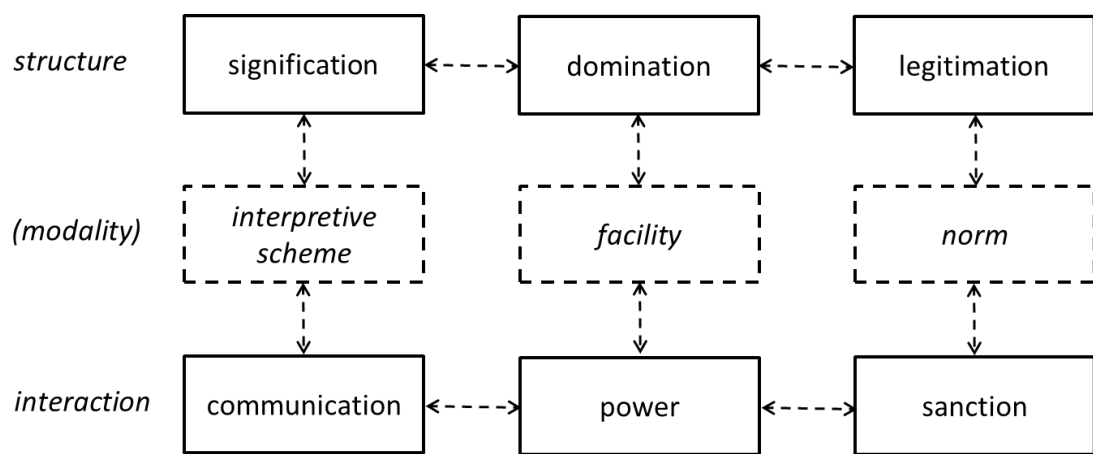
Giddens distinguishes between social 'system' and 'structure'. Structure is defined broadly as 'structuring properties' that allow social practices to be reproduced across time and space in social systems (Giddens, 1984). These structuring properties comprise 'rules' and 'resources', which are 'generalizable procedures' that agents draw upon in the production and reproduction of social action (Giddens, 1989). Rules and resources do not directly determine behaviour, "but they have their effect through being known and used by actors" (Parker, 2000: 57). Human agents learn and apply this type of knowledge in everyday social interaction.

Giddens conceives of the relationship between structure and agency as a duality in which neither exists independently of the other (Parker, 2000). Structure and agency have a dual role as both medium and outcome of the social practices of agents (Giddens, 1984). As Stones explains, "structures serve as the 'medium' of action as they provide, through memory, the bases upon which agents draw when they engage in social practices [...]. Meaningful and ordered social action would be impossible without this 'medium'. Structures are also the outcome of these actions" (Stones, 2005: 16). In this sense, Giddens views structures as having only a virtual existence, as "potentialities" which are invoked at the time of use as structural properties across time and space. Through social action and interaction, agents reproduce the conditions that make these actions possible, resulting in a 'structuring of social life' (Giddens, 1984). Actors necessarily draw on rules and resources from the past, therefore ensuring their continuity into the present. It is only through the purposive action of agents that structures are instantiated and their existence ensured (Parker, 2000).

Giddens (1984) outlines three 'modalities' to explain the duality of structure (Figure 4.4). These modalities are the means by which agents use rules and resources (structures) to mediate interaction. Interpretative schemes provide the 'semantic rules' that agents use to monitor their own and others' activities, and to communicate

their meaning. Norms allow the enacting of normative obligations in social interactions, and the moral sanctioning of others. Facilities refer to the resources which agents control – including economic, allocative, and interpersonal – through the structure of domination to exercise power in interaction and ensure outcomes. The three modalities are not discrete but overlap, so that social actors draw upon all three dimensions as an integrated set of rules and resources in any given social interaction, (Giddens, 1993, Stones, 2005).

**Figure 4.4 Dimensions of the duality of structure**



Source: (Giddens, 1984)

Actions involve a continuous flow of reflexive monitoring which influences further, ongoing action, facilitating the continuity of action over time. As knowledgeable, conscious actors, people continuously monitor and reflect on their actions and the contexts in which they take place. Actors' "knowledgeability", therefore, has a reflexive character. It is not a static condition that determines one action or another; according to Giddens, at a level of practical consciousness, agents reflect on what they know about their actions and why they do them. People can only follow a pattern of behaviour if they can draw on and reflect on what they know about it (i.e. what it is, why it is done, and what happens when it is done), and they can only know this through the continuity of practice. It is through this "continuous monitoring of action" that people construct an aggregate understanding of their behaviour (Giddens, 1984: 3). Furthermore, the capacity to reflexively examine social practices

leads to their reproduction or reformation; actors are both affected by the structures in which they act and are able to change them through their action (Giddens, 1990).

Thompson (1989) critiques aspects of Giddens' formulation of structuration theory. He argues that Giddens' conceptualisation of structure as rules and resources is too vague and ambiguous. Rules have multiple forms, connotations, and applications. Using the idea of 'rules' in a generalised way, as Giddens tends to, fails to account for differential structure of societies and the inequitable opportunities that individuals and groups have to enter and participate in social institutions. In other words, it seems that the idea of 'rules' is not useful to explain how social systems produce inequities in opportunities. Secondly, Giddens seems to underplay the constraining role of certain types of rules and resources. Expressing structural properties in terms of semantic or moral rules fails to explain the constraints that some people experience when faced with a limited range of alternatives, for example due to poverty, as outlined in Rieker and colleagues' (2008, 2010) model of constrained choices described above. Thompson's claim for a greater presence of economic conditions as a constraining factor over action, besides rules and resources, seems to dispute Giddens' attempt at merging structure and agency as 'duality' back towards 'dualism', that is, that structure is not simply instantiated at the time of action but determines action itself.

Like Giddens, Bourdieu moved away from a rigid, constraining conceptualisation of the relationship between structure and agency to one in which agents are considered knowledgeable and skilled social actors. His classic works on the theory and logic of practice (Bourdieu, 1977, [1980] 1990) explained the relationship between practice and context through the concepts of habitus, field, and cultural capital. Bourdieu rejected both the existence of objective mechanisms that almost independently maintain social structures, and the idea of universal, rational, and calculating individuals driven by self-interest (Parker, 2000). Rather, he conceptualised the interdependence of structure and action through the interaction of actors with their external social and material environment (Calhoun, 2011). Through the concept of habitus, Bourdieu explains how actors interpret their experience and engage in practice (Parker, 2000). He defined habitus as "systems of durable, transposable *dispositions*, structured structures predisposed to function as structuring structures,

that is, as principles of the generation and structuring of practices and representations” (Bourdieu, 1977: 72, original emphasis).

Actors acquire habitus through practical experience and repetition (Calhoun, 2011). They internalise social structures through socialisation processes as cognitive, perceptual, and evaluative dispositions that lead to social practices which, in turn, function to reproduce social structures (Mouzelis, 2007). From this perspective, practice is conceptualised as a form of ‘embodied understanding’, an active product of experience which helps actors determine the general principles required to act. This requires them to “relate to the particularity of situations, size them up fast, evaluate them from some point of view, and know what to do – just like a games player” (Parker, 2000: 44). Habitus is more than ‘knowing the rules of the game’; it is a movement towards occupying the position of the player, with the capacity to improvise and an intuitive awareness of what other players are doing. Because actors neither create new actions, nor are fully conscious of the structured historical practices that have shaped their current actions, they engage in what Bourdieu termed “regulated improvisation”. It is through social action that actors both produce and reproduce objective meaning (Bourdieu, 1977: 79).

Bourdieu conceives of action occurring in cultural ‘fields’, social arenas in which actors enact the ‘rules of the game’, each with its own set of rules and stakes (Calhoun, 2011). The field is the site of interaction between social institutions, rules, and involve power struggles and conflict over resources, social position, and domination (Michielsen et al., 2011, Parker, 2000, Webb et al., 2002). The health care field is an example of such a “field of struggle” (Michielsen et al., 2011: 372). Contests occur between competing actors (for example, policy makers and implementers, administrators, pharmaceutical representatives, practitioners, and consumers), each of whom is motivated by self-interest and an ambition to maintain their position (Collyer et al., 2015). However, actors’ ability to achieve this is constrained by the unequal distribution of power, whereby one or more actors have a relative advantage over the others in the same field (Parker, 2000).

A third concept, capital, refers to a set of interrelated resources that actors draw on in their interactions in the field. Different types of capital – economic, social, and

cultural or symbolic – are accumulated over time in material (e.g. economic) or embodied (e.g. cultural, such as social status) forms (Bourdieu, 1986). These types of capital structure the possibilities that are open to individuals and groups and manifest in the social struggles between them (Calhoun, 2011).

There is a clear connection between practice theory and health-seeking, in that health practices can be understood in the context of broader, interrelated social practices. The emphasis on contextualised social actions and interactions “has the potential to resist both the psychologising and the individualising features that ultimately have come to define the term health behaviour” (Cohn, 2014: 160). This is a useful approach to analysing the mechanisms through which health-related practices are socially reproduced and transformed over time (Blue et al., 2016).

While the importance of recognising theories from multiple fields is undoubtable, the prevailing trend of urbanization and its effect on health and health care calls for a theory of health care-seeking that is relevant to the urban global south, grounded in empirical data, and located in broader sociological theories of practice. Collyer (2015) points out the lack of research on the processes through which people make health care choices, and the way those choices are socially structured. The work developed in this thesis attempts to address this gap by examining the practices that women actually do during their maternal health care-seeking. Using theories of practice including structuration as a framework, it seeks to build a better understanding, with concepts developed using grounded theory, of how women and their families interact with a complex health system in the context of maternity care in Mumbai.

#### **4.5 Sociological and anthropological studies of maternal health care in India**

In this section, I provide a qualitative synthesis of recent sociological and anthropological literature on qualitative dimensions of maternal health care in India. I include interview-based studies as well as ethnographic research combining participant observation, informal interviews and historical analysis. The review offers an explanation for the substantial increase in uptake of institutional childbirth

in India and describes how women's interactions with the health system influence their experiences and perceptions of maternity care.

I searched the JStor and Web of Science databases for qualitative and anthropological studies covering adult reproductive health, pregnancy, and childbirth in India. In order to identify a broad range of literature, I began by using the terms 'birth' OR 'pregnancy' OR 'reproductive' AND 'India' in both full text and title fields. Initial searches yielded 2647 results in JStor and 4935 in Web of Science. I refined the search by restricting inclusion criteria to books or book chapters and peer reviewed articles published in qualitative social science journals, mainly covering anthropology, sociology, and women's studies. I also searched for grey literature and reviewed the bibliographies of existing studies to identify additional resources. I read the abstracts of 37 studies and selected 27 for review. Eleven were excluded either because they were not based on primary qualitative data or they did not describe health care-seeking practices. Of the studies included, 16 were ethnographic and 11 qualitative, including one grounded theory study. Twelve studied rural populations, ten were in urban areas (five in informal settlements), and four either did not specify or covered both rural and urban populations. I filtered the range of publications for review by reading the abstracts. I included studies published in English between 2000 and 2019 to reflect recent changes in India's health care system and patterns of maternity care utilisation.

I begin the review by discussing the relationship between generational changes in reproductive social norms and increased utilisation of institutional delivery care. I then consider women's agency and the interdependence of household members in maternal health decision-making, and end the section with a reflection on the rise of medicalisation of childbirth, institutional discrimination, and obstetric violence in India.

The persistently high perinatal mortality rates reported in India have been blamed on the risks associated with rural homebirths and the presence of untrained *dais* during delivery (Naraindas, 2009). Over recent decades, motivated by technical and financial support from international donor organizations, successive governments have implemented a number of 'safe motherhood' campaigns and health



programmes, such as the National Rural Health Mission (NRHM). Collectively, their aim has been to reduce mortality rates by promoting women's utilisation of professional, hospital-based maternity care services (Chattopadhyay et al., 2018). Although these initiatives have resulted in increased institutional delivery and have likely led to reductions in mortality, poor and marginalised groups continue to experience contextual and social obstacles that make institutional maternity care undesirable or problematic.

#### **4.5.1 Constrained care-seeking**

Economic liberalisation policies, the marketization of health care, and a failure of the state to supply adequate essential health care have resulted in reduced access to state services, especially in rural areas (Jeffery and Jeffery, 2008). Ethnographic research in Uttar Pradesh found that the traditional practice of home birth was compounded by poor access to quality or affordable health care, and that decisions to seek obstetric care at a health facility were often taken only in the event of complicated labour (Jeffery and Jeffery, 2010b, Jeffery and Jeffery, 2010a). An interview-based study of childbirth practices in a rural district in Jharkhand state (Barnes, 2007) reported that, besides distance from health care facilities, poor women rarely chose institutional delivery because they worried about costs and feared invasive medical procedures, especially those who had previous negative experiences of care. In Jeffery and Jeffery's ethnographic work (2010b, 2010a), even in obstetric emergencies, care-seeking decisions were often delayed because of contrary advice or resistance from family members, mistrust of public health services and a desire to avoid unprofessional or abusive treatment, and difficulty in raising funds to access private health services in the nearest town.

The expansion of private health care provision has resulted in increasing numbers of women in rural and urban areas seeking institutional childbirth, including at private sector health facilities (Jeffery and Jeffery, 2008, Shah More et al., 2011). Within a changing social and economic landscape, households are making choices about their maternal health care, but these are mostly towards the private sector, resulting in potential impoverishment and detrimental household well-being (Jeffery and Jeffery, 2008). In decisions on level of health facility and choice of provider, priority is often

given to personal experience and perceptions of the quality of service. Griffiths and Stephenson's (2001) study in rural and urban Maharashtra found that women linked paying for care at a private hospital with a safer and more trustworthy service. A small-scale qualitative study in Chhattisgarh state (Jha et al., 2016) reported that, although poor women were limited to public sector childbirth services, and many experienced various forms of mistreatment, they perceived public health facilities to have skilled personnel and equipment for dealing with emergencies and ensuring a safe birth. This finding is relatively uncommon compared with the many studies that report widespread distrust and dissatisfaction with Indian government health facilities (for example, see Jeffery and Jeffery, 2010b, Sidney et al., 2016). Perceptions of public health facilities vary by location and level of institution, with larger, better equipped district hospitals tending to have a better reputation than smaller community-based facilities.

#### **4.5.2 Shifting social norms**

Recent studies in both rural and urban areas clearly show that local cultural beliefs, attitudes, and expectations related to reproductive health are changing. They point to a generational transition in maternal care-seeking in which institutional childbirth is becoming the new social norm (Blanchard et al., 2015, Sidney et al., 2016). The reasons for this transition are varied and include both supply and demand factors. In her ethnography of lower class women in Tamil Nadu, Van Hollen (2003) argues that, in a context of economic growth and demographic transition in urban India, modernisation processes appear to have shaped constructions of maternal health and care-seeking. Women in her study associated delivering in a hospital with being educated and 'modern'. However, despite internalising health care with modernity, many women still feared medicalised childbirth and potential mistreatment by hospital staff. Sidney and colleagues (2016) found that new mothers in two districts in Madhya Pradesh (one mostly urban, the other mostly rural), perceived a need for safe and proper care, and to ensure a quick, easy delivery, all of which were considered more likely at a health facility. They shared common beliefs about the risks of home births and the potential for complications, which could only be managed safely at a hospital. Similarly, in Chhattisgarh, Jha et al. (2016) found that

the safety of the mother and her newborn infant was the main reason women chose hospitals for their births.

Despite inadequate state health care provision, poor rural and urban populations are encouraged or expected to participate – at times, using coercive or punitive means – in health promotion programmes (Jeffery and Jeffery, 2010b). Health facility staff and community outreach workers often try to convince families to use government health facilities (Blanchard et al., 2015). Likewise, ASHAs recruited into the National Health Mission sometimes pressure women to deliver in a facility, help them access and navigate maternal health services, and receive payment for every woman they refer (Sidney et al., 2016).

The acceptance and internalisation of new social norms and expectations in the general population can also create opportunities for some women who wish to utilise reproductive health services. Rather than constraining behaviour, these conditions create a "beneficial environment" that provides an opportunity for women to enact preferred health practices (Paul et al., 2017: 316). However, Van Hollen's ethnography (2003) points to an ontological conflict between modernity and maternity. On one hand, women had internalised medical discourses from state and international bodies that promote institutional childbirth and associated delivering in a hospital with being 'knowledgeable' and 'modern'. On the other, they experienced class, caste, and gender discrimination and mistreatment from hospital staff, who considered them uneducated and ignorant of their own health. Through this, dominant unequal social and political hierarchical structures were reproduced. Van Hollen argued that, although women exercised 'choice' regarding where to deliver, their choices were shaped by broader political and economic structures, and that decisions to deliver at home were more about avoiding institutionalised discrimination than a 'preference' for home births or rejection of hospital care.

#### **4.5.3 Structure and agency in maternal health decision-making**

The studies reviewed in this qualitative synthesis suggest that women's participation in decisions about their own health care varies across geographical region and is influenced by the social and cultural context. Traditionally, various other women in a

pregnant woman's immediate and wider social network were involved in the process and rituals of childbirth (Naraindas, 2009). Several studies in rural and urban areas describe an interdependence of family members' roles and the consideration of their collective attitudes and experiences in health decision-making (Blanchard et al., 2015, Raman et al., 2016). Gender and household power dynamics also play an important role. In India, after women marry, their mothers-in-law gain considerable influence over their reproductive health, although this is not universal and varies with reproductive issue. Whereas in rural South India young married women tend to receive considerable support from their natal family, in Northern and Central regions they tend to be more dependent on their in-laws, even in nuclear families (Char et al., 2010). In a qualitative study from rural Jharkhand, female family members managed homebirths, but decisions relating to childbirth outside the home were usually taken by husbands and brothers-in-law; pregnant women were largely excluded or their views were ignored (Barnes, 2007).

Raman (2016) argues that women's decision-making is related to their status within the family hierarchy, affecting their ability to make decisions across domains. Women living in joint families rarely make independent decisions regarding their own maternal health care (Raman et al., 2016, Sudhinaraset et al., 2016). Even among higher status urban women, maternal health care decisions were made collectively (Raman et al., 2016). Mothers-in-law have particular authority over aspects of younger women's reproductive health practices and decisions, although not universally (Char et al., 2010). In Raman's (2016) study, in-laws exercised considerable authority over household matters across class, caste, and religious backgrounds. Lack of control in one domain is related to a corresponding lack of control in another. For example, agency in reproductive health decisions has been linked with agency in decisions about marriage. Older, multiparous, more educated women seem to have more agency over related decisions and practices, including marriage and fertility and choice of delivery site (Raman et al., 2014, Sidney et al., 2016). In contrast, low status women from poor households can experience limited agency by being excluded from decision-making or the imposition of family expectations (Raman, 2014).

Unnithan-Kumar (2003) argues that, among rural-urban migrant women living in informal settlements, friendship and support among *basti* women take on an important role in information-sharing on issues such as reproductive health practices and health care providers. As well as changes in social organisation and networks compared with their villages, migrant women's reproductive health agency is constrained by lack of direct access to food production and an increased burden of domestic work. Although they experience more freedom in decision-making from immediate family and greater availability of health care providers, they are constrained by a lack of female relatives to facilitate mobility and by new forms of reproductive control created by a medicalised system of maternity care.

The role that members of women's social networks have in their health care may be related to the concept of authoritative knowledge. This is knowledge that is developed through social interaction and involves contested power relations defining whose knowledge "counts" and how it is produced and contested, often in relation to a medicalised model of maternity (Sargent and Gulbas, 2011). One study showed how women's individual agency was limited by the collective intentions of other, more powerful stakeholders (for example, the in-laws), or they had to act without their knowledge. They were rarely able to enact their intentions, such as to use contraception to prevent pregnancy (Paul et al., 2017). Raman (2014) argued that a normalisation of reproductive processes including marriage, pregnancy, and childbirth, and the central role that extended family members play in these practices, meant that there was little expectation for women to exercise individual autonomy.

However, not all women comply with the preferences or decisions of other family members; some exercise agency in carrying out their own preferences (Blanchard et al., 2015). The fact that women rarely make household decisions independently and often ask other family members and negotiate is not necessarily an indication of powerlessness. Raman et al. (2016) argue that many women agree with their in-laws' involvement in their health care-seeking. Moreover, Blanchard and colleagues' (2015) study in rural Karnataka showed that, despite their relatively low household social status, pregnant women did not always comply with the decisions of in-laws and elders, and sometimes chose to deliver at their own preferred site. That is, higher

status household members considered pregnant women's preferred delivery sites even when they disagreed with them.

#### **4.5.4 Experiences of health care utilisation**

Women and members of their social network draw on their experiences of health care in decisions regarding the uptake of institutional health services and choice of provider (Sudhinaraset et al., 2016). Both positive and negative experiences and perceptions influence choice between a hospital and home birth, as well as the type of health care sector and provider (Blanchard et al., 2015, Griffiths and Stephenson, 2001, Sudhinaraset et al., 2016).

Studies reveal a preference for health care facilities that families feel offer higher standards of care or have sufficient resources to provide specialist care to ensure a positive health outcome. Outcome-oriented decisions are often driven by a concern for the safety of the mother and child, a desire to avoid unnecessary medical intervention, and a preference for a normal birth (Sudhinaraset et al., 2016, Unnithan-Kumar, 2003). Of importance are perceptions of faith and trust that choosing a superior care provider will increase the chances of a positive maternity experience and pregnancy outcome (Jeffery and Jeffery, 2010a). For the disempowered poor, the religious aspect of faith becomes an especially important and integrated aspect of seeking adequate health care: "faith in a doctor, faith in a hospital, faith in God" (Raman, 2014: 79).

#### **4.5.5 Violence, discrimination, and dissatisfaction**

One consequence of the global emphasis of 'safe motherhood' on increasing coverage of institutional maternity care in India is that women's experiences with health services and providers are often overlooked (Chattopadhyay et al., 2018). Poor and marginalised groups often report dissatisfaction with their perinatal health care and are disproportionately affected by mistreatment and poor quality care (Chattopadhyay et al., 2018). One manifestation is violence and abuse during childbirth (obstetric violence), a form of gender-based violence set within a broader context of structural inequalities. As Unnithan-Kumar (2003: 185) asserts, "poverty, caste, class and state medical control all combine to violate women's sense of bodily

integrity.” A propensity for disrespectful care reflects broader discriminatory attitudes and behaviour by state institutions (Khanday and Tanwar, 2013). Gupta (2012) explores this in detail in his ethnography of forms and mechanisms of structural violence perpetrated by state bureaucracy in India. Paradoxically, poor groups are included in welfare policies and programmes that provide care, but also experience structural violence within the services that the state agencies and actors implement.

Some Indian studies describe the way in which gendered violence intersects with other forms of structural inequality to produce violence during pregnancy and childbirth (Chattopadhyay et al., 2018). The experience of care and abuse in health facilities is nuanced; not all women experience health services, quality of care, and interaction with facility staff equally. Studies also describe various forms of discrimination that women from socially and culturally marginalised groups experience within the health system. While some suggest a general culture of disrespect towards low status clients among public and private providers (for example, see Sudhinaraset et al., 2016), most argue that poor quality interactions and experiences of medical care are more prevalent in the public sector. In this context, discrimination occurs across various axes including class, caste, and religion (see for example, Pinto, 2008, Van Hollen, 2003). Forms of discrimination and mistreatment in health facilities can manifest in various ways, including denial of services, corrupt practices (e.g. demanding money after childbirth), demeaning or insensitive demands (e.g. being asked to undress in public), and obstetric violence (Khanday and Tanwar, 2013, Unnithan-Kumar, 2015).

Muslim women often experience poor quality and disrespectful care based on their low status, high fertility, and delayed care-seeking, which may be interpreted as a failure to conform to social and biomedical behavioural norms (Jeffery and Jeffery, 2008, Jeffery and Jeffery, 2010b). Madhiwalla and colleagues (2018) described disrespectful attitudes of staff in a tertiary government hospital towards low status women, especially Muslims, for not following medical advice. Chattopadhyay (2018) also noted that non-payment of state-mandated cash benefits was higher for Muslim mothers compared to other groups under the Janani Suraksha Yojana (JSY).

Discrimination and abuse has a direct impact on women's experiences and perceptions of care. Chattopadhyay (2018) notes the disempowering effect of cumulative axes of inequity that leave low status women without the social, economic, and cultural capital to confront mistreatment and disrespect in health care settings. Families who choose institutional delivery may have to tolerate discriminatory behaviour because they cannot afford services at better quality facilities (Khanday and Tanwar, 2013). Disrespectful care is also an important factor in women's decisions to resist or delay care-seeking, or to avoid institutional delivery. Many women who give birth at home do so because of concerns about their treatment at a facility based on their class and social status (Jeffery and Jeffery, 2010a, Sudhinaraset et al., 2016, Unnithan-Kumar, 2015). Those who can may try to target specific health providers who they perceive are sensitive to cultural beliefs and practices, more respectful in their interaction, or less likely to use invasive medical procedures, (Raman, 2014).

This chapter examined dominant models of health-seeking and outlined the strengths and limitations of each before discussing sociological debates on agency and structure, and their relationship to health care-seeking. I identified social practice theory and structuration as useful frameworks in the conceptualisation of maternity care-seeking. I ended the chapter with a review of recent sociological and anthropological literature from rural and urban India describing the influence of social and cultural phenomena on maternal health-seeking, and women's experiences of care. In the following chapter, I introduce the country and context in which the study took place.

## **Chapter 5 Study setting**

The preceding chapters have outlined the global scale and nature of perinatal mortality, and examined existing health-behaviour and health care-seeking models in social psychology, sociology, and anthropology. This chapter gives an overview of the study setting before presenting the quantitative findings and grounded theory in the following two chapters. It provides some demographic, economic and socio-political information on India and Mumbai, emphasising the relevance of urbanisation and the expansion of urban informal settlements to health and health



care. It describes the structure of India's pluralistic health system, the different roles and presence of the public and private sectors, and reviews recent research on maternal health care-seeking in Mumbai's informal settlements.

## **5.1 Brief introduction to India**

India is a geographically vast and socio-culturally diverse country in South Asia. Spanning more than 3.2 million km<sup>2</sup> it is bordered by Pakistan, Afghanistan, China, Nepal, Bhutan, Myanmar, and Bangladesh (Nag, 1992) (Figure 5.1). It comprises 29 States and seven Union Territories. The Indian Constitution recognises 22 different languages, although Hindi is the official language (Government of India, 2015).

According to the 2011 national census, the population has surpassed 1.2 billion, making it the world's second most populous nation. There are almost 624 million males and 587 million females (Government of India, 2011). Around 70% of the population live in rural areas and are mostly dependent on agriculture for their livelihood. It is the world's fastest urbanising country; currently, there are 410 million Indians living in towns and cities (United Nations, 2014). India currently has three mega-cities – urban areas with a population of over 10 million: Mumbai, Delhi, and Kolkata (Chandramouli, 2011).

A recent expert group constituted by the Indian Government Planning Commission estimated that 363 million Indians (29.5% of the population) were living below the poverty line in 2011-12 (calculation based on a monthly per-household expenditure of 4,860 Rupees (USD <100) in rural India and 7,035 Rupees (USD <150) in urban India assuming a family of five). Although the ratio has improved and more than 90 million people were lifted out of poverty between 2009-10 to 2011-12 (an average reduction of ~9% per year), more than 260 million people in rural areas (31% of the rural population) and 102 million in urban areas (26% of the urban population) were still below poverty line thresholds (Government of India Planning Commission, 2014).

**Figure 5.1. Map of India, showing Maharashtra state and Mumbai city**



### **5.1.1 Health care system**

India's health system is characterised by medical pluralism. Studies have described the population's use of various types of health practitioner and services (Durkin-Longley, 1984, The World Bank, 1996). The official system under the Ministry of Health and Family Welfare is biomedicine, although the Department of AYUSH (ayurveda, yoga, unani, siddha, and homeopathy) oversees indigenous and folk medical traditions. Studies by western social anthropologists during the post-independence period claimed cultural resistance to biomedicine, especially in villages. However, people's choice of medical system in India is arguably more about socio-political issues of availability, accessibility and quality (Minocha, 1980, Sujatha and Abraham, 2012). Economic liberalisation policies during the 1980s and 1990s had an impact on people's access to health care. The role of the state in the provision of care changed from being a primary provider to increasing privatisation and greater emphasis on citizens taking responsibility for their own health care (Jeffery and Jeffery, 2008). The private health care sector has burgeoned to fill the

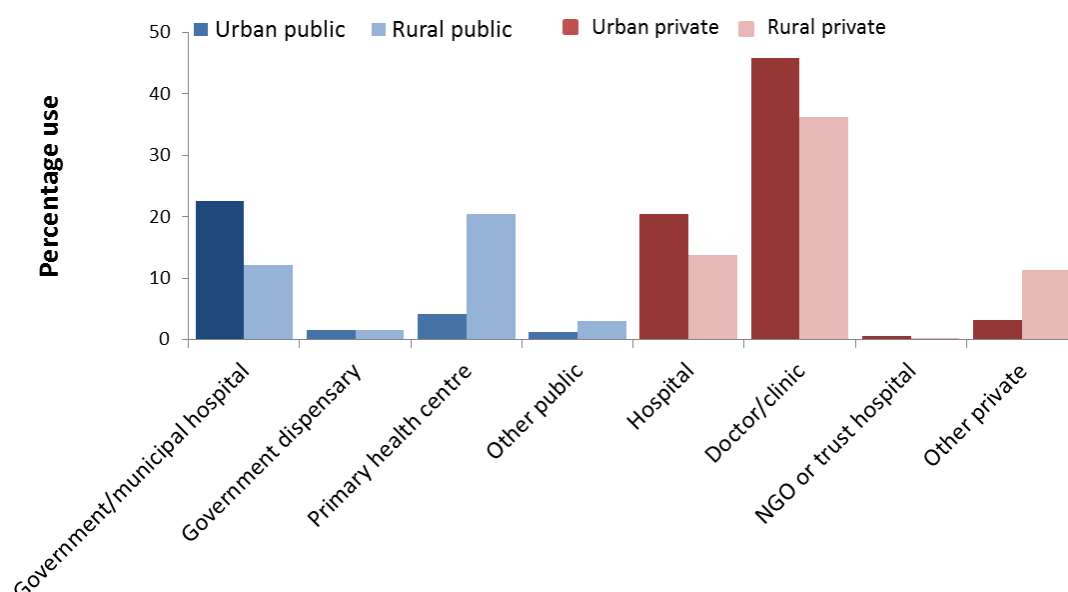
gap left by an underfunded, inadequate public sector (Municipal Corporation of Greater Mumbai, 2010).

In sections 2.4.2, I introduced India's *Janani Shishu Suraksha Karyakram* (JSSK) and *Janani Suraskha Yojana* (JSY), which both provide financial incentives for women to use institutional maternity care. Another important health programme, the Integrated Child Development Services (ICDS) administers *anganwadis* (childcare centres) in underserved areas, which provide health, nutrition, and educational services to children up to six years, and nutritional and health services to pregnant and breastfeeding women (Gupta et al., 2009).

The private sector includes super-speciality hospitals, medium-sized facilities that provide both outpatient and inpatient care, and a substantial number of smaller practices that offer limited services. It has been estimated that there are well over 1.25 million untrained practitioners in India, the vast majority of whom are not registered, qualified, or regulated (Radwan, 2005). The sector is poorly regulated and many practitioners are either underqualified or lack formal training (Baru, 2005, De Zoysa et al., 1998). Provider competence and the quality of medical care vary and it is often unclear whether practitioners are adequately qualified or trained to practice the type of medicine they do.

The private sector dominates the provision of healthcare overall. Several studies affirm the urban preference for private sector care (Aljunid, 1995, Bhatia and Cleland, 2001, Gupta and Dasgupta, 2000). Figure 5.2 illustrates the main sources of health care in rural and urban areas. It affirms that the urban population seek more health care from public and private hospitals, but also underlines the popularity of private practitioners working from smaller clinics.

**Figure 5.2. Source of health care in India by rural and urban areas**



(Adapted from: International Institute for Population Sciences and Macro International, 2007)

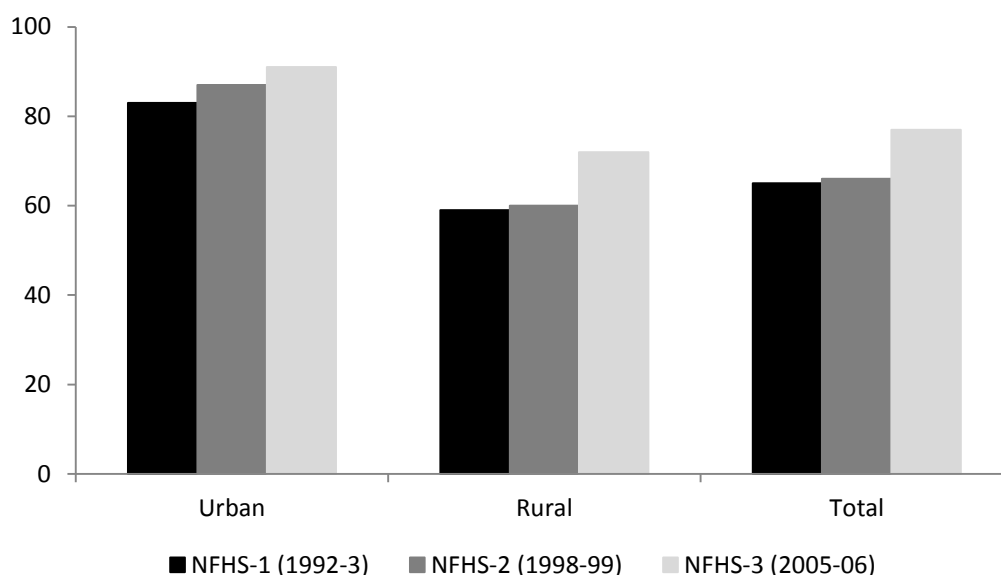
Most inpatient care is provided by public hospitals and outpatient care by the private sector (International Institute for Population Sciences and Macro International, 2007). Access is limited by the ability to pay, although expectations that they will receive a superior service and more courteous treatment may explain even poorer people's willingness to meet the costs (De Zoysa et al., 1998, Gupta and Dasgupta, 2000, Kausar et al., 1999, The World Bank, 1996). Residents often prefer the private sector because of ease of accessibility, convenient timings, and a perception that the quality of care is superior (Barua and Pandav, 2011, Ergler et al., 2011, Kielmann et al., 2005).

### 5.1.2 Maternal health care utilisation

Levels of maternal health care-seeking in India as a whole remain at suboptimal levels. Recent DHS data reported that less than 21% of women across India received sufficient prenatal care and less than half (42%) had an institutional delivery (Yadav and Kesarwani, 2015). However, uptake has increased in recent decades, mostly in

rural areas where health care use has been relatively low, although care-seeking rates are consistently higher in urban areas (Figure 5.3).

**Figure 5.3. Trends in prenatal care uptake by residence, India 1998-2006**



(Source: International Institute for Population Sciences and Macro International, 2007)

The urban poor have worse indicators of maternal health care than in the non-poor. At national and state levels, utilisation of maternal health care is considerably lower among the poor than the non-poor. Data from the National Family Health Survey (NFHS-3) report levels of prenatal care-seeking at 45% among the urban poor compared with 71% among the non-poor, and skilled delivery 84% and 50%, respectively. Indicators are poorer in several newly-urbanising states with underdeveloped health care infrastructure and services, such as Rajasthan, Uttar Pradesh, Madhya Pradesh and Bihar (Prakash and Kumar, 2013).

## 5.2 Mumbai

Mumbai, the capital city of Maharashtra state, is a long, narrow peninsula on the west coast of India (see Figure 5.1 above). Historically, it comprised a group of seven islands which were connected through land reclamation during British rule. Mumbai was originally inhabited by the *Kolis*, a fisher people indigenous to the area and who inhabited various stretches of the coast. Urban expansion, and waves of

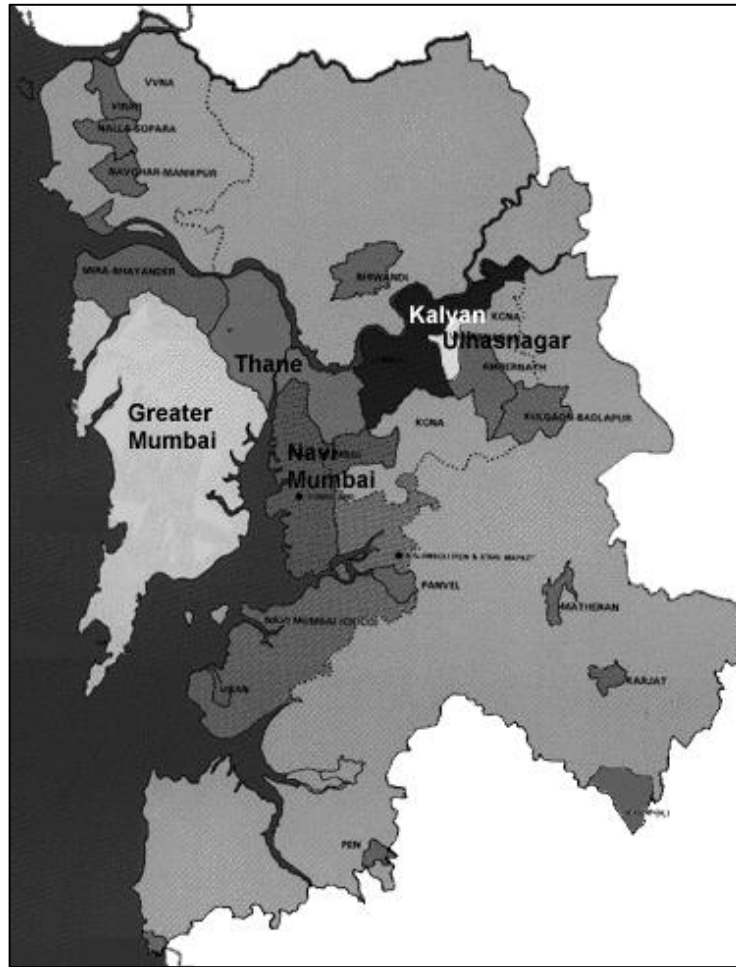
economic and development projects have had encroached on many *Koli* communities, forcing some away from their traditional habitats and ruining the livelihood of others (Municipal Corporation of Greater Mumbai, 2010, Warhaft, 2001).

### **5.2.1 Demography and urban growth**

The Mumbai Metropolitan Region (MMR, Figure 5.4) spreads over 4355 km<sup>2</sup> and comprises the city and its neighbouring districts (Mumbai Metropolitan Region Development Authority, 2013). The MMR population exceeds 20 million, making it the sixth largest urban agglomeration in the world, behind Tokyo (38m), Delhi (25m), Shanghai (23m), Mexico City (21m), and São Paulo (21m) (United Nations, 2014).

Industrialisation and manufacturing growth increased Mumbai's commercial importance and, facilitated by the development of the port and the construction of a rail connection, it attracted huge numbers of skilled and unskilled workers from across India. By 1864, the population already exceeded 800,000 (Municipal Corporation of Greater Mumbai, 2010, Risbud, 2003).

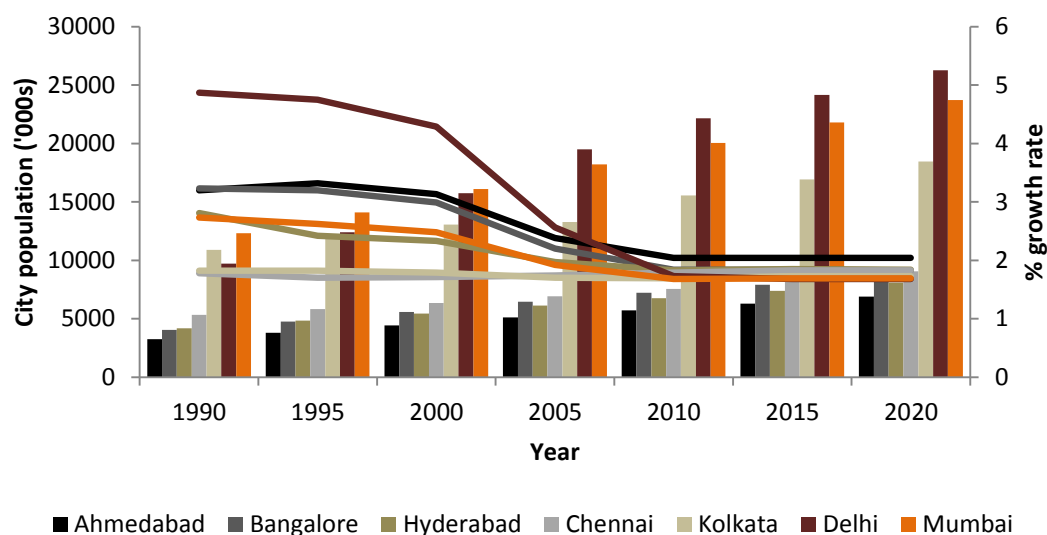
**Figure 5.4. The Mumbai Metropolitan Region**



(Source: Municipal Corporation of Greater Mumbai, 2010)

Since the 1970s, when the island city became more congested, the population has expanded into the central and northern suburbs (Risbud, 2003). Between 1950 and 2000, Mumbai experienced an average annual population increase of 262,000 (Satterthwaite, 2005). In the 1990s, although the urban growth rate declined and stabilised, the population has continued to rise (Figure 5.5). Currently more than 16 million people live in Mumbai, making it India's second largest city (United Nations, 2014).

**Figure 5.5. Population and growth rate of urban agglomerations in selected Indian cities**



(Source: UN-HABITAT, 2013. Note, bars show population and lines % growth rates)

## 5.2.2 Governance

Mumbai's 24 municipal wards are administered by the Municipal Corporation of Greater Mumbai (MCGM), one of the oldest and largest civic bodies in India. The role of the MCGM is to provide basic amenities such as public health, water and sanitation, education, transport and road maintenance. Greater Mumbai is the largest and most populous urban area in the MMR and is divided into three geographical areas: City (69 sq. km.), Western Suburbs (211 sq. km.), and Eastern Suburbs (158 sq. km.). Although the area covers only about 10% of the MMR, it accounts for more than 60% of the region's population (Municipal Corporation of Greater Mumbai, 2010).

## 5.2.3 Economy

Mumbai has a diverse economy and contributes almost 40% to the Indian economy through its port, manufacturing industry, government, and financial institutions, trade, and services, and is known as the 'commercial capital of India' (Risbud, 2003).



As traditional industries have closed or relocated, it has gradually transitioned into a service sector economy, including significant employment in the informal sector. Three-quarters of employment is provided by tertiary-sector activities, including transport and communication, trade, banking and insurance, real estate, and public administration (Municipal Corporation of Greater Mumbai, 2010).

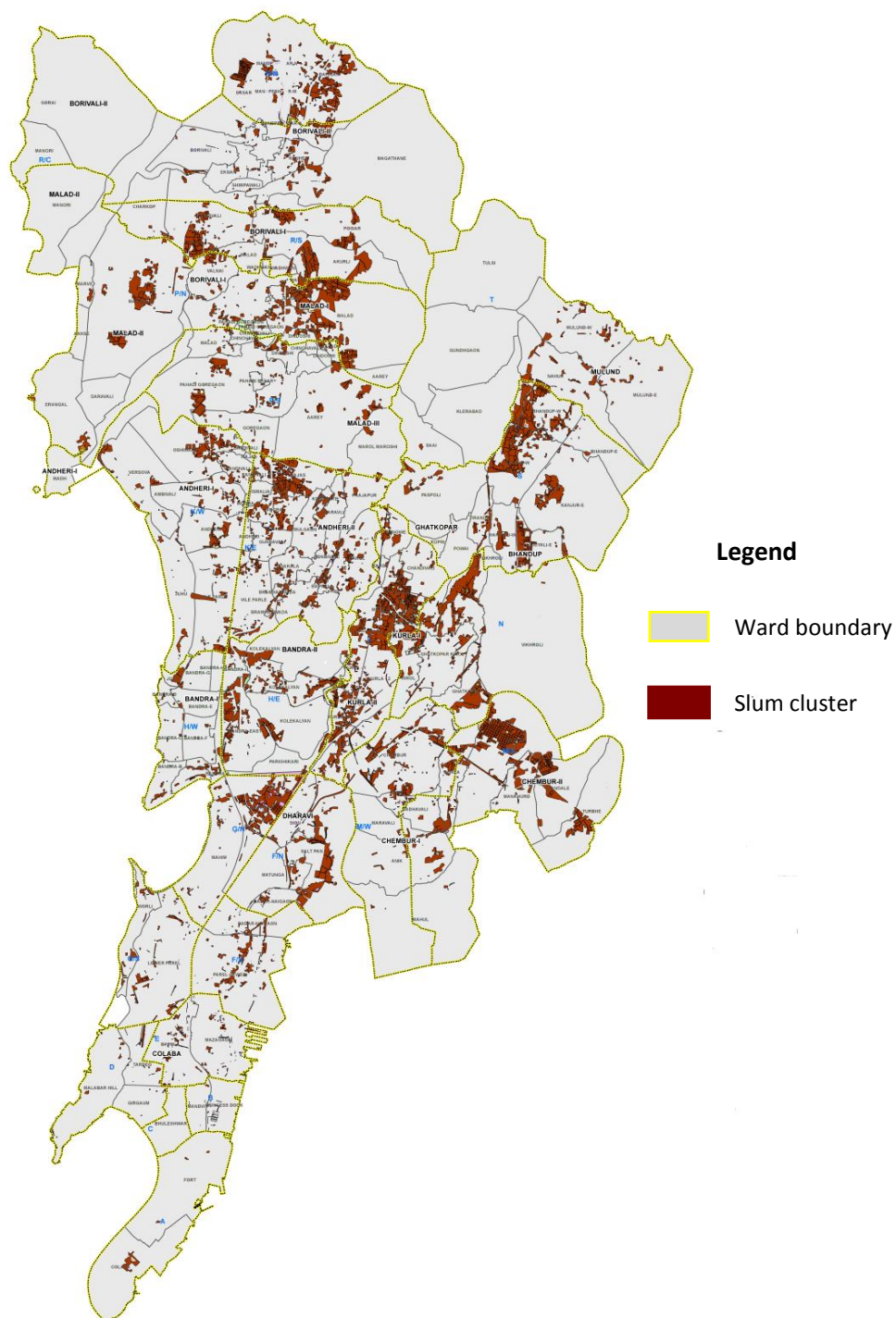
#### **5.2.4 Urban poverty and informal settlements**

Severe housing shortages in the 1930s led to the emergence of informal settlements or ‘slums’. The slum population rose sharply during the 1970s but was not officially ‘accepted’ until the 1980s (Bhide, 2009). Informal settlements are a visible manifestation of urban inequality and poverty, and a dominant feature of Mumbai’s landscape. They are found in almost every municipal ward; most are in the western suburbs, followed by the eastern suburbs and, to a much smaller extent, the southern island city (Figure 5.6). There are a recorded 2400 slum clusters in Greater Mumbai (Slum Rehabilitation Authority, 2016).

More than half (56%) of Mumbai’s population live in informal settlements and more than 15% of India’s slum population are in Mumbai. About half of people living in the western suburbs, and three-quarters of those in the eastern suburbs, live in informal settlements. Not all poor people live in slums and not all slum-dwellers are poor. However, poverty is more prevalent in informal settlements than other urban areas and there are many more slum households than poor households (Gupta et al., 2009).

Mumbai’s urban poor live in different types of dwelling: *chawls* are single rooms in single- or multi-storey tenement buildings originally constructed for low-income factory workers, *zopadpattis*, are usually temporary or semi-permanent constructions in informal settlement communities, while others live in pavement dwellings constructed on footpaths and alongside roads (Municipal Corporation of Greater Mumbai, 2005, Municipal Corporation of Greater Mumbai, 2010).

**Figure 5.6. Slum clusters in Greater Mumbai, showing ward boundaries – GPS survey 2015-16**



(Adapted from: Slum Rehabilitation Authority, 2016)

### **5.2.5 Social and health indicators**

Unregistered or non-notified slums (generally those established since 1995) are considered illegal, because of which civic bodies do not provide access to basic services and residents live with the threat of eviction and demolition. Informal settlements are often cramped, unsanitary environments. Overcrowding, income inequality and poverty, and an unaffordable and inadequate housing sector have contributed to an exponential growth in the number and size of slums (Municipal Corporation of Greater Mumbai, 2010).

Disaggregated data from a publication deriving from the Indian National Family Health Survey (NFHS-3) 2005-06 provide a snapshot of social and health indicators for the urban poor and the slum and non-slum population (Gupta et al., 2009). Primary and secondary school attendance for boys and girls is much lower among the urban poor, and educational levels of both men and women are much lower in informal settlements. The sex ratio among the urban poor is very low (556 females per 1000 males) compared to the urban average (890), reflecting the pattern of immigration of poor young men. However, a lower proportion of men (45%) are migrants than women (51%). Women are less likely to be in paid employment; those who are tend to work in service industries.

The urban poor are particularly disadvantaged with respect to quality of housing, access to sanitary toilet facilities, prenatal and delivery care, and exposure to spousal violence. The average household size is similar across socio-demographic groups at around 4.5. Although households across the city as a whole have less than 1.5 sleeping rooms each and an average of 2.3 people per room, one-in-five households in informal settlements have seven or more people per room. While almost all slum households have access to piped water, either in the house or from an external source, less than one-quarter (21%) have a private toilet, half the proportion of non-slum households, but much more than the poorest urban quartile (3%).

While average health indicators are relatively good in Mumbai compared to other cities, the gap between slums and non-slums is large. Residents of informal settlements score lower on social and health indicators, and the urban poor generally

report the worst indicators. The infant mortality rate (IMR) is lower in Mumbai than other cities (30 deaths per 1000 live births). Around 70% of children 12-23 months from slum (69%) and non-slum (73%) households have received full vaccinations, but under-five malnutrition is relatively high: 26% of non-slum children, 36% of slum children, and 46% of the poorest are classified as underweight. Health care system

Mumbai's public sector infrastructure includes teaching hospitals, specialist hospitals, peripheral general hospitals, maternity hospitals, and community-level health posts and dispensaries (Brihan Mumbai Corporation, 2009). The Municipal Corporation of Greater Mumbai (MCGM) – India's largest and wealthiest civic organization – provides more than a quarter of the approximately 40,000 hospital beds available across the city and is a major healthcare provider for the poor (Municipal Corporation of Greater Mumbai, 2005). The level of care is laudable in terms of accessibility and affordability, but it is challenged by an unequal distribution of infrastructure and shortages of staff and equipment. The public system has been beleaguered by reports of poor accountability, an inefficient referral system, long outpatient queues and poor staff attitudes (Barua, 2005, Joshi, 2008, Ministry of Health and Family Welfare, 2013b).

Municipal health posts provide prenatal care, immunizations, and family planning. Maternity hospitals are typically located in, or near, residential areas and have between 20 and 100 beds. They are designated to manage routine births; complicated cases are referred to better-equipped secondary or tertiary facilities. Staffing levels are largely dictated by the average annual number of births, which range from 25 to 45 per month, although vacancies are often unfilled. Each hospital is headed by a Medical Officer (MO) who acts as clinician-administrator. Other doctors may also be present. The MO is assisted by a sister-in-charge, who carries out administrative duties and supervises a team of trained nurses, auxiliary nurses, and housekeeping staff (*ayabais* and *mhetranis*). Most municipal wards have at least one public hospital and residents of informal settlements have access to a large number of private health facilities. For example, in one of the study areas (L ward), which has a population of almost one million, there is only one municipal hospital, but 447 private practitioners (Municipal Corporation of Greater Mumbai, 2010).

Private health care facilities and providers abound. The exact number of informal providers in Mumbai is not known, although, in Delhi, there are an estimated 40,000 unqualified ‘quacks’ (Perappadan, 2008). Some providers are trained in one medical system, such as homoeopathy, but incorporate practices from other disciplines, usually biomedicine. This ‘cross-practice’ is common, especially in smaller clinics (Dilip and Duggal, 2004). Some practitioners reportedly refuse to provide required treatment or offer substandard services (Bhate-Deosthali et al., 2011, Mahajan, 2010); reports of poorly-functioning clinics and malpractice regularly occur in the local, national, and international press. Private physicians are commonly accused of acting in pursuit of profit, overprescribing treatments, referring clients to particular hospitals for a commission, and receiving incentives from pharmaceutical companies to promote their products over other brands (McGivering, 2013, Mishra, 2014, Pandit, 2015). Despite the popularity of the private sector, research has highlighted deficiencies in infrastructure, services, and personnel. For example, a study of 24 private nursing homes in Mumbai found that 50% were in poor condition and poorly maintained (Nandraj et al., 2001). Most had no scrubbing room or waste disposal facilities and less than one-third employed qualified nurses (Baru, 2005).

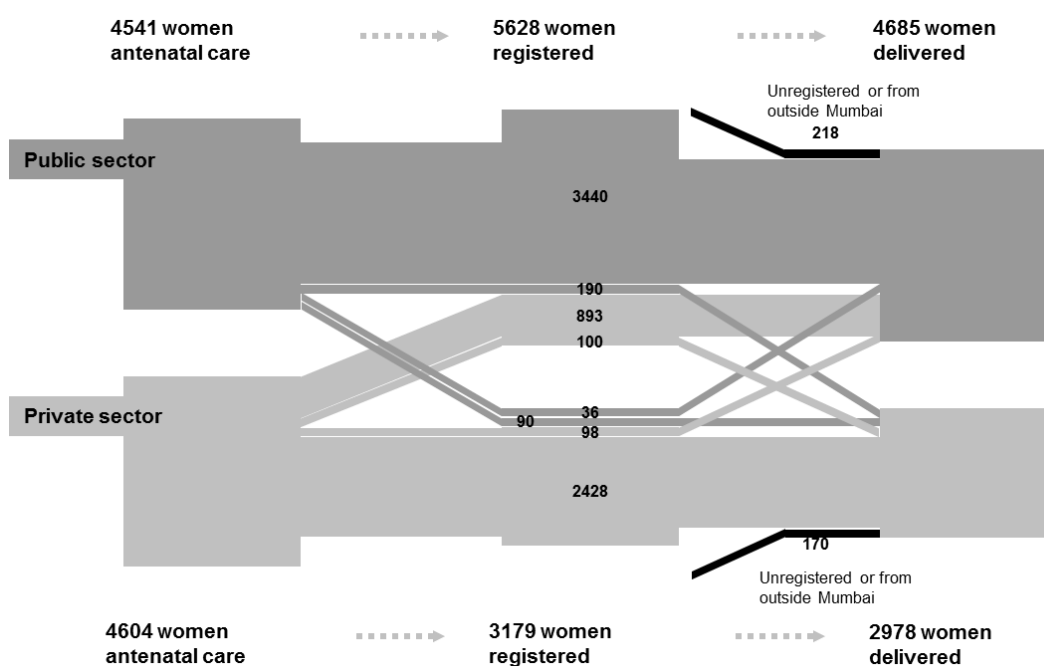
#### **5.2.6 Maternity care-seeking in Mumbai’s informal settlements**

Few studies have collected and analysed primary data on maternal health and care-seeking in Mumbai’s informal settlements. In order to give an overview, I present findings from two studies conducted with women in six of Mumbai’s municipal wards (F North, G North, H East, K West, M East, P North) (Shah More et al., 2009a, Shah More et al., 2011). The studies were part of a community-based trial of women’s groups to improve maternal and newborn health outcomes and analysed baseline survey data for 10,754 women (Shah More et al., 2008).

One study analysed prenatal and delivery care patterns (Shah More et al., 2009a). Across the six wards, 93% of women made at least one prenatal care visit, and of those, 95% made three or more visits. Half sought care in the public sector and half chose private providers. Municipal general hospitals and maternity hospitals were the commonest source of public sector prenatal care, while in the private sector, hospitals and individual practitioners were both popular. 66% of women delivered in

a health facility and 10% had a home birth – most reported the reasons as rapid onset of labour or unavailability of someone to accompany them to a health facility. Most women registered their pregnancy (as mentioned in section 3.4.2, registration is a requirement in the public sector) and delivered in the same health sector and facility (Figure 5.7). About one-quarter returned to their natal homes for the birth (a common custom for primiparous women). Of women who had prenatal care in the private sector, 22% switched to public sector care. These were mostly women who had sought prenatal care from individual practitioners who do not provide child birth services. Most movement within the public sector was upwards to a higher level facility, either because of dissatisfaction with care or referral for possible complication.

**Figure 5.7. Care-seeking pathways from prenatal to delivery care in Mumbai.**



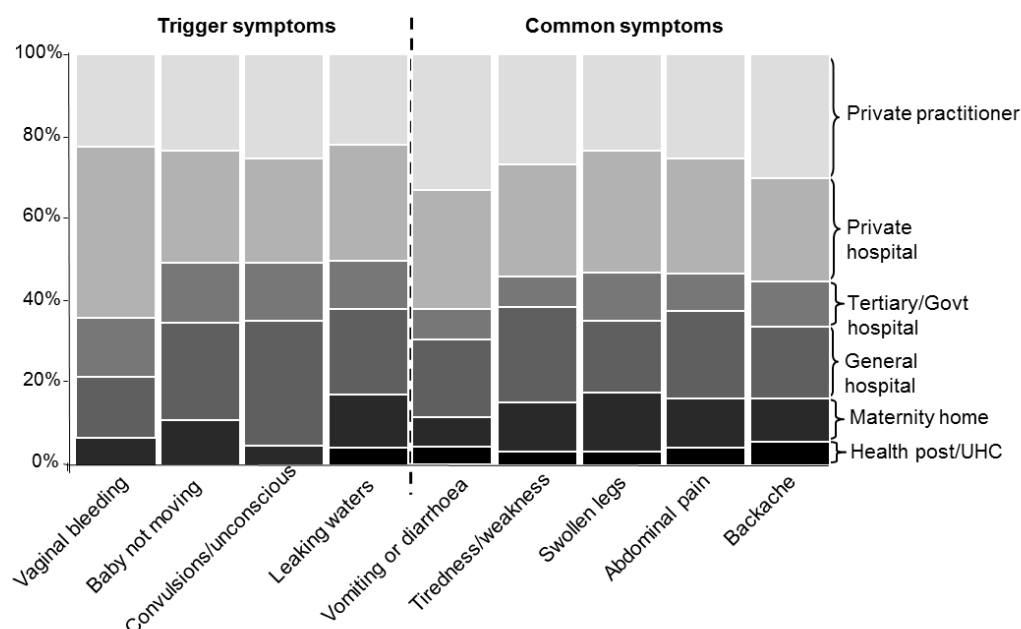
Light grey: clients who began prenatal care in the public sector. Dark grey: clients who began in the private sector. Dotted line: notional divide between public and private sectors. The breadth of each path is proportional to the number of clients.

(Source: Shah More et al., 2009a)

The second study analysed the choice of provider for health problems during pregnancy (Shah More et al., 2011). 60% of women reported experiencing one or more health problems during their last pregnancy, mainly common symptoms associated with pregnancy (e.g. vomiting, tiredness, swollen legs). Again, institutional care-seeking was high: from 82% to 91% for common symptoms, and from 88% to 100% for more serious 'trigger' symptoms indicative of complication for which prompt consultation with a medical professional would be recommended (e.g. leaking amniotic fluid, bleeding). Most women sought care within two days of the onset of symptoms at the health facility where they were receiving prenatal care.

Care-seeking sites for three of the trigger symptoms were split evenly between the private and public sectors, although there was an overall preference for private health care (54%) Figure 5.8). Whereas two-thirds who chose the private sector for the treatment of vaginal bleeding did so at a hospital, more clients sought care for vomiting or diarrhoea and backache from individual practitioners. In the public sector, general hospitals were the commonest site, where almost a third of all clients sought treatment for convulsions or unconsciousness. With the exception of vaginal bleeding, the seriousness of a symptom had little effect on the choice of one sector or facility-type over another. The use of tertiary public hospitals was higher for women who resided in the same or adjacent ward to the hospital. Whereas primiparous women tended to use the private sector, multiparous women sought care in both sectors. Results of logistic regression showed a positive association between socio-economic level and the use of the private sector. Utilisation of private hospitals was commonest among the least poor, while the poorest group tended to consult with individual practitioners and make use of public sector services.

**Figure 5.8. Choice of health provider for selected symptoms during pregnancy in Mumbai**



(Source: Shah More et al., 2011)

Both studies show that the demand for preventive and curative maternity care among women in Mumbai's informal settlements is high. This suggests that women perceive a need for health care, can recognise symptoms of complication, and are able to access resources and negotiate the health system to seek appropriate services. Patterns of private and public sector utilisation are mixed. There is a clear preference for private sector care, but access is limited by socio-economic status. Larger municipal hospitals are popular, so much so that people often bypass smaller health posts and urban health centres. Time and convenience are a premium; smaller facilities have lower levels of staffing levels and equipment, and provide fewer health services.



### **5.3 The SNEHA Centre trial**

The research for this thesis was conducted within a community-based cluster randomised controlled trial to test the effects of community resource centres on the health and nutrition of women and children living in Mumbai's informal settlements (Shah More et al., 2013). The trial ran from 2011 to 2015 and was a collaboration between the Institute for Global Health, University College London (UCL), and the Society for Nutrition, Education and Health Action (SNEHA), a Mumbai-based NGO. Trial clusters were located in two of 24 municipal wards in eastern Mumbai (M East and L), each with a population of around 700,000.

The wards were chosen because they ranked lowest on the UN Human Development Index for the city. They have a high concentration of slum residency (78% and 85%, respectively), high infant mortality (66 and 55 per 1000), lower life expectancy, and lower female literacy and employment (Municipal Corporation of Greater Mumbai, 2010). Informal settlements in these wards have grown over the last 20 years. Most have surfaced roads and electricity supply, and access to schools. Since they are in low-lying areas, monsoon flooding is common, and some are located near city's largest garbage dump. Both wards have substantial migrant and Muslim populations, and extensive unauthorized housing.

In the trial areas, there are nine health posts, one Urban Health Centre, and one maternity hospital. The nearest tertiary public hospital is about 20 minutes away by public transport. Many private health providers with a range of qualifications, mostly practicing biomedicine (allopathy) and homeopathy, with some unani practitioners located in, or in close proximity to, the clusters. These individual practitioners provide services that are tailored to local conditions.

The trial was implemented in 40 informal settlements, 20 allocated to have community resource centres and 20 controls. Allocation was done in three blocks, of 12, 12 and 16 clusters, in a phased design with 6-month intervals between the start of each phase (Figure 5.9).

**Figure 5.9. Map of eastern Mumbai showing SNEHA Centre trial clusters**



Primary trial outcome indicators were unmet need for family planning in women aged 15 to 49 years, immunization of children under 5 years, and nutritional status of children under 5 years. There were seven secondary outcomes: number of consultations for violence against women or children, proportion of home deliveries for births in the preceding year, proportion of pregnancies in the preceding two years to women under 20 years, proportions of children under five with anthropometric stunting and underweight, proportion of children born in the preceding two years who received government childhood services, and proportion of children achieving WHO Infant and Young Child Feeding core indicators (Shah More et al., 2013, World Health Organization, 2008). Outcomes were assessed through census interviews in both intervention and control clusters, before and after two years of implementation.

The intervention functioned through community resource centres (“SNEHA Centres”), usually a rented single-room in an accessible location in each intervention area. SNEHA Centres acted as bases for the collection and dissemination of health information and community-based action. Three salaried, full-time Community Organisers (COs) with at least ninth grade education and similar socio-economic

backgrounds to potential beneficiaries worked from a centre and were responsible for 200 households in each cluster. Their work included beneficiary group meetings and home visits, community awareness campaigns, and collaborative health promotion events, such as immunization camps based around reproductive, maternal, and newborn health, child health and nutrition, and prevention of violence against women and children (Shah More et al., 2017).

This chapter has provided a brief overview of India and the setting in Mumbai which the study took place. It described a context of urban growth and migration, health care pluralism, and the important roles that both public and private providers play in the provision of health care. It explained the SNEHA Centre trial, a large cluster randomised controlled trial in 48 areas, and reported inequitable patterns of maternity care utilisation in informal settlements from two related studies. This should provide a useful backdrop to compare with this study which was conducted in informal settlements in two municipal wards in the city's eastern suburbs.

In the following chapter, I describe the mixed methods design used in this study, combining sequential quantitative and qualitative sampling, data collection, and analysis, paying particular attention to the development of the grounded theory.

## **Chapter 6 Methods**

### **6.1 Introduction**

I begin the methods chapter by outlining the aims and objectives of the research. In section 5.3, I describe the process of selecting an appropriate mixed methods design and explain the role of both qualitative and quantitative methods in the study. Section 5.4 describes the philosophical roots and variations of grounded theory, its main principles, and methods. In section 5.5, I describe my use of both the substantive and methodological literature in the research. I dedicate space to this here because of contentions about the role and timing of using pre-existing knowledge in grounded theory. The following three sections describe the implementation of the quantitative and qualitative methods, including sampling (5.6), data collection and management (5.7), and analysis and theory development (5.8). In section 5.9, I conclude the chapter with some reflections on my role as a researcher and their implications for the research.

### **6.2 Aims and objectives**

The aim of the research was to explore the dynamics of maternal health care-seeking by women living in Mumbai's informal settlements. Within this, there were two main objectives: (1) to quantify patterns of uptake of maternity care and choice of provider, and (2) to develop a grounded theory to help explain the patterns. I believed that an empirically-derived substantive theory of maternity care-seeking in Mumbai's informal settlements would be useful to understand health care utilisation in similar settings in low- and middle income countries.

### **6.3 Study design**

As outlined in the introduction, I planned and designed the study in collaboration with colleagues from UCL and SNEHA. I defined the aim and objectives through a series of discussions based on our previous work in Mumbai (Shah More et al., 2009a, Shah More et al., 2011, Shah More et al., 2010). As a foreign male with a basic knowledge of Hindi, talking to local women about their maternity experiences would be difficult. Therefore, I recruited two female postgraduate research assistants.

Both were from Mumbai and were fluent in Hindi and Marathi (the language of Maharashtra state). One had an academic background in disaster management and sociology, and the other was an Ayurvedic doctor with a postgraduate degree in public health. I provided training on qualitative data collection methods and in-depth interviewing, translation and transcription, data management and confidentiality, and qualitative analysis using NVivo software ([www.qsrinternational.com](http://www.qsrinternational.com)). Both researchers were integral to the study, not only assisting with the research process but also acting as “cultural brokers” with the local community (Green and Thorogood, 2004, Temple and Young, 2004: 171).

I developed a mixed methods design, using quantitative and qualitative methods to address the research objectives. I believed that combining both approaches would enable a more comprehensive examination of maternal health care-seeking. I wanted to understand the patterns of maternity service uptake and site of prenatal and delivery care, then to examine the potential determinants of uptake and choice of provider by individual and family social, economic, and demographic variables. Implicit in the quantitative analysis was the identification of inequalities in access to different levels of provider across the public and private sectors. I used the results of the quantitative analyses to identify patterns of maternity care utilisation and choice of provider for qualitative investigation. I had become aware of the limitations of epidemiological research, including the focus on individual behaviour and absence of analyses of broad social forces in which it takes place, and a call for greater integration of social theory (Wemrell et al., 2016). Therefore, I conducted a qualitative exploration of the social context and mechanisms underlying the observed care-seeking patterns. Finally, I was interested in how women made sense of their experiences and how these might be related to ongoing health-seeking practices.

Qualitative methods have become increasingly popular in health research, contributing broadly to knowledge on the social and cultural aspects of health and illness, health behaviours, and health care services (Green and Thorogood, 2004, Lambert and McKevitt, 2002, Pope and Mays, 1995). They can be particularly useful in situations where variables and theories related to a topic are not well understood (Creswell, 1998). Qualitative methods aim to understand social phenomena in their natural settings and the meanings that people give to them (Denzin and Lincoln,

1994). With an emphasis on understanding experiences, attitudes and behaviours from the participants' perspectives, qualitative methods seek to uncover what people really think, how they really behave, and what they actually mean when they talk about it (Pope and Mays, 1995). Observation and interviews provide a better sense of "real life" than quantitative methods (Cockerham and Scambler, 2010: 8-9). These methodological approaches make qualitative research particularly appropriate for examining social processes, behaviours, or interactions in the contexts in which they exist (Creswell, 1998).

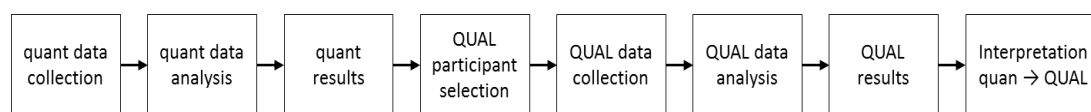
Mixing methods has also gained credibility in health research because of the numerous, complex factors that influence health (Morgan, 1998). The main benefit is that it allows the researcher to combine the strengths of one method with those of another (Morgan, 1998, Morse, 1991). However, the process can be difficult because of the ontological and epistemological differences between quantitative and qualitative methodologies, and challenges linked to the technical aspects of combining methods (Bryman, 2007, Morgan, 1998).

There are various types of mixed methods design. Creswell and Plano Clark (2007) identified four major functional classifications: the Triangulation Design, the Embedded Design, the Explanatory Design, and the Exploratory Design. Designs tend to differ in the role, weight, and timing given to quantitative and qualitative methods. The role of each method depends on the research question and involves prioritising one method and timing, or sequence, deciding whether the priority method will be used first or second (Creswell and Plano Clark, 2007, Morgan, 1998).

Among the options, triangulation and explanation seemed potentially useful designs. Morse (1991) defines triangulation broadly as a process of "obtaining complementary findings that strengthen research results and contribute to theory and knowledge development" (p. 122). Creswell and Plano (2007) describe it procedurally as "a one-phase design in which researchers implement the quantitative and qualitative methods during the same timeframe and with equal weight" (pp. 63-4). It involves directly comparing quantitative results with qualitative findings, or validating or expanding quantitative results with qualitative data.

The explanatory design is a two-phase, sequential model in which the results of a preliminary quantitative phase are subsequently explained or elaborated on using qualitative methods (Creswell and Plano Clark, 2007). The design also supports the use of quantitative results to identify groups for qualitative follow up (Morgan, 1998). Figure 6.1 visualises the sequence and priority of methods used in the participant selection variant of the explanatory design. The sequence, indicated by the arrows connecting each phase, shows that quantitative data collection, analysis, and reporting precede the qualitative phases. As the priority method, the qualitative components are indicated by the use of capital letters (“QUAL”) and the complementary method in lower case (Morse, 1991). The first phase involves the collection and analysis of quantitative data, the results of which are used to inform a subsequent qualitative phase of data collection and analysis (Creswell and Plano Clark, 2007, Morgan, 1998).

**Figure 6.1. Explanatory design: participant selection model**



Source: (Creswell and Plano Clark, 2007: 73)

The participant selection variant of the explanatory method seemed more suitable because of its straightforward design, sequential, two-phase implementation, and support of purposive selection of relevant cases (Creswell and Plano Clark, 2007). In addition, the method allows the researcher to follow up on some of the quantitative results in qualitative interviews. I considered both methods important. Combined, they have the potential for a more comprehensive understanding of phenomena. I prioritised the qualitative component: understanding women’s social experiences and lived realities is suited to an inductive, qualitative approach (Mason, 2006). In contrast with many health care-seeking studies, I wanted to focus on explaining patterns of care-seeking rather than describing them. Finally, my medical anthropology background and research experience lent itself to a qualitative approach.

There are several qualitative research traditions (for an explanation of five key qualitative methods, see Creswell, 1998). Grounded theory has been used extensively in several academic fields and was appropriate for this study. One attraction was the claim that different types of data can be used to generate a theory (Glaser, 1978, Glaser, 1992). According to Glaser (1992), “qualitative analysis may be done with data arrived at quantitatively or qualitatively or in some combination” (p. 11). However, quantitative methodologies rely on objective, numerical measures and statistical tests, involving the use of existing theory and predefined relationships between concepts. This runs contrary to central principles of grounded theory, which emphasise induction and emergence (Glaser, 1992, Glaser and Strauss, 1967). It was unclear to me exactly how to integrate quantitative and qualitative methods into a grounded theory. With the exception of a dense, technical chapter in Glaser and Strauss’s *Discovery of Grounded Theory* (Glaser and Strauss, 1967), there are surprisingly few explanations of how to do it. I therefore decided to treat the quantitative and qualitative data separately and sequentially to address different aspects of the same research question as I felt this would be a pragmatic approach to using the different types of data.

## **6.4 Grounded theory**

### **6.4.1 Overview**

Grounded theory is a general research methodology for developing theory about social phenomena. In contrast to deductive, hypothesis-testing approaches, the emphasis of classic grounded theory is the discovery of concepts that are ‘grounded’ in the data. It has become a widely used research methodology (Gibson and Hartman, 2013). In grounded theory studies the researcher tries to uncover the main concern or problem experienced by participants in a substantive area and explain how it is resolved (Glaser, 1978, Hernandez, 2009). Systematic procedures centre on:

... generating concepts and their relationships that explain, account for and interpret the variation in behaviour in [a] substantive area under study [sic], which behaviour is most often hinged around processing a problem for the subjects (Glaser, 1992: 19)



The methodology was developed in the 1960s by sociologists Barney Glaser and Anselm Strauss while researching interactions between medical staff and terminally ill patients. Disenchanted with the dominance of theory verification in the social sciences, they believed that theory generation from empirical data deserved equal emphasis (Kenny and Fourie, 2014). Two years after they completed their research (Glaser and Strauss, 1965b), they redressed the balance by publishing their seminal methodology book, *The Discovery of Grounded Theory* (Glaser and Strauss, 1967).

Grounded theory has its philosophical roots in symbolic interactionism (Aldiabat and Le Navenec, 2011, Corbin and Strauss, 1990, Heath and Cowley, 2004), a sociological perspective which emphasises the influence of subjective meaning and interaction on social behaviour. Blumer (1969) conceptualised three basic tenets of symbolic interactionism: firstly, the ways in which people act towards objects and phenomena reflect the subjective meanings they assign to them; secondly, the assigned meanings are derived from social interaction; and, thirdly, the meanings are managed and modified through an interpretive social process.

Since its original formulation – known as ‘Classic’ grounded theory – other versions have evolved. The differences are ontological and methodological (Hallberg, 2006). Classic grounded theory leans towards critical realism, which stipulates the existence of a natural objective reality independent of the researcher. It takes an emic perspective, using an inductive, qualitative approach to discover real, objective concepts and generate a theory that actually exists in the data (Annells, 1996). Strauss developed a different approach that rejected the positivist orientation of classic grounded theory (Strauss and Corbin, 1994). Strauss grounded theory leans towards relativism, whereby multiple perspectives on external reality exist through subjective interpretation (Annells, 1996). Strauss argued that the researcher’s pre-existing knowledge plays a role in the interpretation of data (Reichert, 2010). In this sense, the theory is locally constructed and verified throughout the research, rather than representing a generalizable ‘real’ reality. The researcher is seen as integral to the method, constructing and verifying knowledge through a transactional process with the data (Annells, 1996, Hallberg, 2006). While Glaser remained faithful to the original formulation, Strauss and Corbin (1990) published their version in *Basics of qualitative research: grounded theory procedures and techniques*.

Glaser rebuked the work in a published response, *Basics of grounded theory analysis: emergence vs forcing* (Glaser, 1992). He argued that it forced categories on the data, was not grounded theory, and at best could only achieve “full conceptual description” (Glaser, 1992: 123).

A third variant, constructivist grounded theory, was developed Kathy Charmaz, a student of both Glaser and Strauss. Constructivism takes the postmodernist position that researchers cannot stand removed from research participants. Multiple, simultaneous social realities exist, which are defined, interpreted and co-constructed through interaction between the researcher and the participants (Charmaz, 2006, Hallberg, 2006). Glaser argues that the constructivists’ concern with accurate description of participants’ multiple perspectives and co-constructed stories is misplaced. Although he acknowledges the existence of multiple perspectives, his formulation of grounded theory emphasises conceptual abstraction and the discovery of underlying patterns (Glaser, 2002a). Charmaz concedes that, in practice, grounded theory studies are usually neither completely objectivist nor constructivist, but contain elements of both.

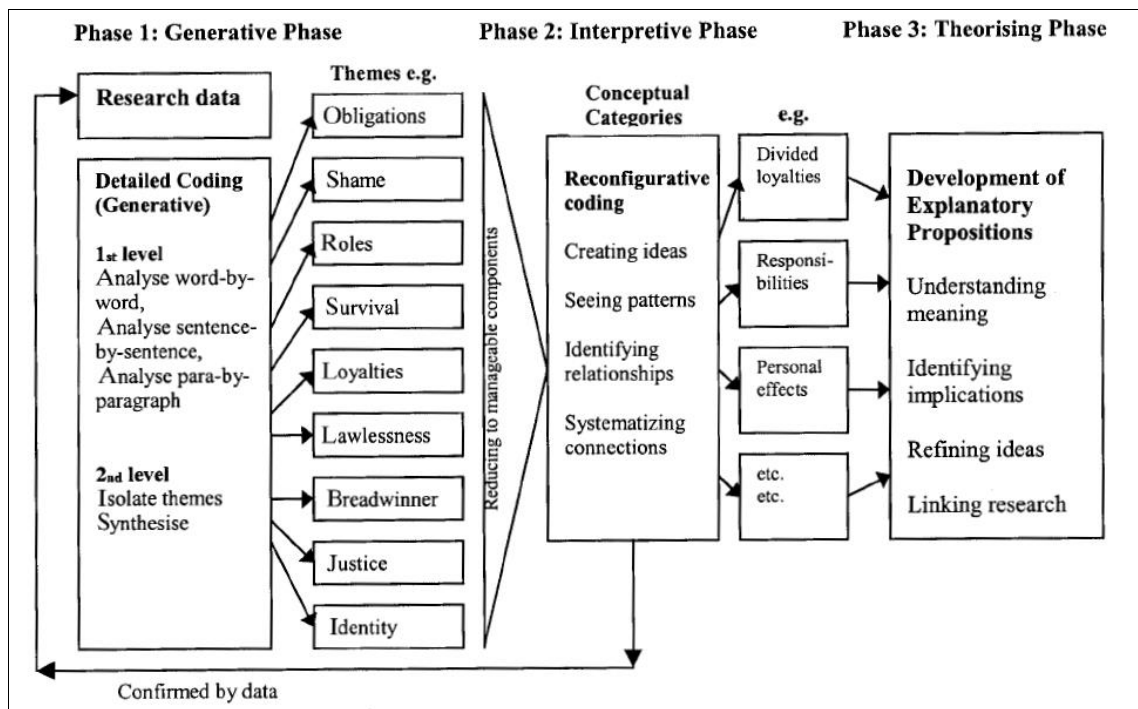
Of the major variations, I chose classic grounded theory. As the original methodology, it has gained widespread acclaim and has been applied across many research areas, including health-related behaviours. Its ontological and epistemological position also lent itself to a mixed methods approach. It is highly regarded for its emphasis on inductive theory generation, keeping the researcher close to the substantive data and lived realities of participants (Glaser and Strauss, 1967).

Grounded theories often explain underlying processes and action. Glaser recommends that the researcher look for a ‘basic social process’ (BSP) which “explains the organization of behaviour (as emergent informal organization) to address the main concern of the participants” (Holton, 2007: 285). The BSP is a process that resolves a social or psychological problem experienced by participants and is a common type of theoretical category in grounded theory studies. According to Glaser and Holton (2005), qualitative methods are ideal for identifying social processes and to generate grounded theory.

### 6.4.2 Methods in classic grounded theory

Grounded theory follows an iterative process of collecting, coding, and analysing data. During the initial stage of analysis, the researcher identifies ‘incidents’ in the data such as events, occurrences, and social action (Glaser, 1978, Strauss, 1987). These indicate underlying patterns that can be coded conceptually. Analysis involves constantly comparing incidents or indicators to identify similarities and differences; indicators that appear conceptually similar are grouped under a higher-level conceptual category, which forms the basis of the theory. New data are compared with existing codes, which are refined and sharpened to achieve the best fit for the data until each category is conceptually saturated (Corbin and Strauss, 2008, Glaser, 1992, Strauss, 1987). Constantly comparing data forces the researcher to consider common and distinct features of incidents and variations in meaning in order to develop the full range of conceptual categories, properties, and dimensions. More theoretical categories emerge, which eventually encompass all of the collected data (see Figure 6.2 for an illustrative example).

**Figure 6.2. Qualitative data analysis and theory generation**



Source (Connolly 2003: 108)

#### **6.4.2.1 Coding**

Qualitative codes are words or phrases that symbolically represent or summarise sections of textual or visual data (Saldaña, 2009). In grounded theory, coding aims to develop a set of conceptual categories and relationships as hypotheses in a substantive area (Glaser and Strauss, 1965c). Two major coding phases in classic grounded theory are substantive and theoretical. In substantive coding, open and selective codes “conceptualize the empirical substance of the area of research”. Theoretical coding relates the substantive codes at a conceptual level to form the theory (Glaser, 1978: 55-56).

Lofland and Lofland (2006) refer to open coding as “the rubber hitting the road” – the point at which the researcher starts making sense of the data in relation to the research topic or area of interest (p. 201). It involves closely examining data to identify indicators of phenomena, “fracturing” them into smaller pieces, and “running the data open” by labelling them with codes that represent multiple possible meanings (Glaser, 1978: 56). Data are often fractured at the level of individual lines, sentences, or words (Charmaz, 2006, Glaser, 1978: 56). Line-by-line analysis helps identify a wide range of indicators from different theoretical perspectives, minimising the imposition of preconceived ideas, personal assumptions, and bias.

Codes are later reconstructed by grouping them into broader analytical categories (Glaser, 1978, Holton, 2007, Strauss, 1987). LaRossa (2005) proposes two main ways of categorising data: grouping similar things that distinguish them from other things and grouping things that are not necessarily similar but have something in common into more abstract categories (e.g. hiding toys and grabbing toys are strategies to avoid sharing toys) (p. 842-43). The latter requires more conceptual thought and leads to theory construction. As conceptual categories and their properties emerge through abstraction, the relationships between them form an integrated theoretical framework based on a central concept, or ‘core’ category. The core category represents a pattern that explains a process, behaviour or other social phenomenon (Glaser and Strauss, 1967, Rhine, 2010).

Theoretical coding is more abstract and seeks a theoretical understanding of the empirical data. Glaser developed a set of 18 theoretical coding families (Glaser,

1978) to sensitise the researcher to a wide range of potential codes. Developing a conceptual understanding of the emerging theory requires the researcher to develop theoretical sensitivity, the quality of bringing professional and personal theoretical knowledge to the data to provide theoretical insight and meaning relevant to the area of inquiry (Strauss and Corbin, 1990).

#### **6.4.2.2 *Writing memos***

Writing memos is crucial to generating grounded theory. Memos are personal notes about a hypothesis, a category, property or, importantly, the relationships between categories. They can take any form, from a few words or set of questions to several pages of analytical notes. Glaser recommends writing freely and quickly to capture thoughts and reflections on the data (Glaser, 1978). They make the analytical process “stronger, clearer, and more theoretical” (Charmaz, 2006: 115).

#### **6.4.2.3 *Theoretical sampling***

As data are generated and analysed through constant comparison, emerging theoretical concepts and categories are used to direct further sampling and data collection. This inductive approach means coding data according to the researcher’s emerging conceptual understanding of them (Glaser, 1978). Theoretical sampling involves identifying individuals and situations that will help refine and saturate emerging concepts, properties and dimensions to develop the theory. It is essential that theoretical sampling is guided by the generated codes rather than preconceived ideas or existing theory.

#### **6.4.2.4 *Selective coding***

Selective or focused coding usually begins after an emerging theory has developed around a core category. This phase involves selecting groups of analytically-interesting open codes, bringing together larger sections of data, and asking more focused and analytical questions of them (Lofland and Lofland, 2006). Subsequent data collection and coding are limited to those categories that fit within the boundaries of the theory (Glaser and Strauss, 1967).

#### **6.4.2.5 *Sorting and writing***

Once a sufficient number of memos have been generated, they are sorted in a way that restructures the fractured data (Glaser, 1978). Sorting involves comparing and integrating conceptual categories into a theoretical formulation, and provides the structure and content with which to write up the theory (Charmaz, 2006).

### **6.5 Use of the literature**

I drew on a variety of literature throughout the study, including quantitative and qualitative materials from academic textbooks, as well as theoretical and empirical studies in peer-reviewed journals. Since the process was complex, I describe it in more detail below.

#### **6.5.1 Quantitative**

Quantitative and mixed methods papers provided information on patterns of maternity care uptake and utilisation in low- and middle-income countries. I have described my search strategy for literature on patterns and determinants of maternal health care-seeking in Chapter 3. It is worth mentioning that my work with international and local non-governmental health organisations in low- and middle income countries heightened my curiosity towards inequalities in health and health care-seeking. While this is likely to have influenced my interest in and interpretation of the literature, I was mindful of the fact that these terms are social constructions and whose local meaning should also be considered (Harris, 2006).

#### **6.5.2 Qualitative**

There is some dispute regarding when and how to use the literature in grounded theory research (Charmaz, 2006, McCallin, 2003, McGhee et al., 2007). Classic grounded theory texts recommend delaying the literature review to minimise bias arising from pre-existing concepts or the researcher's preconceived ideas in the generation of theory (Glaser, 1992, Glaser and Strauss, 1967). This can help ensure that the emerging theory will be grounded in data (Cutcliffe, 2000). However, others argue that this is inevitable because researchers "bring to the inquiry a considerable background in professional and disciplinary literature" (Strauss and Corbin, 1990:

48). Literature reviews identify existing work relevant to the study area and gaps in knowledge, and help define the study aims. Strauss and Corbin (1990) argue that knowledge of existing concepts and relationships can enhance the researcher's theoretical sensitivity and that these concepts can be compared with emerging data. Knowledge of related concepts does not necessarily mean that they will be imposed on new empirical data, and "there is a difference between an open mind and empty head" (Dey, 2003: 65). Furthermore, students are expected to demonstrate a good understanding of relevant literature before starting fieldwork and researchers seeking funding or ethical approval need to review existing research.

I had no prior knowledge of grounded theory methods and reviewed some introductory texts on social science theory and model building (see Jaccard and Jacoby, 2010, Lave and March, 1993). I studied seminal grounded theory books (Charmaz, 2006, Glaser and Strauss, 1967, Strauss and Corbin, 1990) and reviewed a number of empirical qualitative and grounded theory studies in various academic fields to examine how the authors had conceptualised their data and produced explanatory models (see for example: Bigus, 1972, Charmaz, 1990, Glaser and Strauss, 1965a). I accessed several grounded theory PhD theses through university websites or from the British Library EThOS repository (<http://ethos.bl.uk>). Examples included a study of terminal haemodialysis patients (Calvin, 2000), a theory of interdisciplinary practice among health care professionals (McCallin, 1999), and a study of homoeopathic practitioners in the UK (Eyles, 2009). I also read a variety of published grounded theory articles on a range of topics by both experienced and inexperienced grounded theorists. I regularly checked the tables of contents of several academic journals in the health and social sciences and reference lists in academic manuscripts for additional literature relevant to my study, which I might have missed by the use of search terms alone.

I reviewed some of the dominant multidisciplinary health- and health-seeking behaviour theories because I felt it was important to broaden my understanding of the cross-disciplinary theoretical orientations and conceptual frameworks. I believed this would open me up to the breadth of concepts in the theoretical health behaviour literature and avoid imposing my professional and experiential knowledge on the research. I came to the study with some knowledge of health seeking behaviour and

health care utilisation in Peru (Alcock, 2002, Alcock, 2006) and India (Shah More et al., 2009a, Shah More et al., 2011, Shah More et al., 2010). The studies I collaborated on used retrospective qualitative or mixed methods designs to produce descriptive accounts. I was interested in exploring what pregnant women and their families actually did when faced with decisions about maternity care, and how they engaged with health services.

## **6.6 Evaluating grounded theory**

Researchers have different criteria for evaluating grounded theories. Strauss and Corbin (1990) distinguish between three sets of issues: (1) validity, reliability, and credibility of the data, (2) the adequacy of the research process which led to the generation of theory, and (3) the empirical grounding of the research findings. Similarly, Charmaz (2006) suggests assessing credibility, originality, resonance, and usefulness. Credibility refers to the depth and breadth of the data, the systematic use of comparison across a range of observations, linkages between data and emerging theory, and the strength of evidence to support the research claims. The conceptual categories developed throughout the study should offer new insights and an original view of the data, should be significant, and should extend current understanding of the phenomena. They should also account for a wide range of incidents and events. The resulting theory should be applicable to everyday worlds and generic processes, as well as provide impetus for further research in other substantive areas.

In the original formulation of grounded theory, Glaser and Strauss (1967) argued that a grounded theory should have fit, relevance, and work, ensuring that the data rather than pre-existing concepts and ideas drive the explanation of how the participants make sense of their experience and manage their situation. Glaser later added a fourth criterion, modifiability, meaning that the theory should be open to modification on the basis of new conditions or incidents in the data (Glaser, 1978, Glaser, 1992).

Qualitative researchers sometimes are sometimes expected to return to the field to verify their understanding and interpretation of the data with study participants. Charmaz (2006) suggests that the resonance of the grounded theory be tested in this



way. However, Glaser (2002b) argues that this is unnecessary because participants rarely comprehend their circumstances and behaviour at a conceptual level in a way that is brought out by the research. Because a grounded theory is systematically generated through the constant comparison of empirical data and guided by the emerging theory, it inherently has an internal rigour that does not require external verification (Glaser, 1978). During the development of the emerging theory, relevant substantive studies can be brought in for comparison, whereby the researcher “reconciles differences, shows similarities in concepts and patterns, and imbues his work with the data and concepts in the literature” (Glaser, 1992: 33). A pragmatic approach is to evaluate and critique the most important works that are related to categories developed in the grounded theory (Charmaz, 2006).

Rather than relying on the application of prescribed steps, producing a rigorous grounded theory seems to depend on the researcher’s sensitivity to the range of theoretical perspectives within the data and on having the imagination and creativity to present the research, not as a series of findings or facts, but as an integrated conceptual framework.

### **6.6.1 Ethical considerations**

Ethical considerations for the study included baseline data collection, the use of personal information in the trial, and the qualitative data collection, analysis and management.

#### **6.6.1.1 *Consent***

All participants gave written consent prior to interview for the baseline census and verbal consent for qualitative interview. Once I had identified women to invite for qualitative focus groups or interviews, I contacted the SNEHA Community Organiser (CO) assigned to the household. As field staff in intervention areas, the COs were our principal means of access through their daily interaction with the local community. The CO explained the purpose of the study to each of the women and invited them to attend a qualitative interview or focus group discussion. Prior to commencing the activity, the researcher explained in more detail the purpose and nature of the research and the reason for inviting them. Participants were provided

with an information sheet (Appendix C) and given assurances about anonymity and confidentiality of personal information. The researcher conducting the interview sought verbal consent, which was recorded on a consent form (Appendix D). Forms were stored in the SNEHA Centre program office. Since the participants had already been explained about the study and were free to choose whether or not to attend an interview, I judged verbal consent sufficient.

The researcher replaced the participants' names with pseudonyms during transcription. I recorded the names and locations of health facilities that participants had identified as pseudonyms. No participant, location, or health facility name appeared in its original form in transcripts, communications, presentations, manuscripts, or any draft of the thesis.

#### ***6.6.1.2 Ethical approval***

The SNEHA Centres trial was approved by the Multi-Institutional Ethics Committee of the Anusandhan Trust in Mumbai and by the University College London Research Ethics Committee (reference 3546/001, January 2012). Ethical approval for the PhD research was granted by the University College London Research Ethics Committee (reference: 1994/001, November 2010) and the Multi-institutional Ethics Committee of the Anusandhan Trust in Mumbai on 28<sup>th</sup> December 2010. I also registered the research project with the UCL data protection office.

### **6.7 Data sources and sampling**

Two quantitative datasets were used in the study: (1) the trial baseline census was used for the descriptive quantitative analysis of maternity care uptake and pattern of utilisation of health providers, and (2) the intervention monitoring database, which included up-to-date information on maternal status and health care behaviours in each household. I used this database to identify participants for the qualitative interviews (explained in more detail in section 5.7.2).

#### **6.7.1 Quantitative sampling**

All married women in the 15–49 year age group and resident in trial areas (16,462) were covered by the baseline sample. The actual ages of respondents included in the

census ranged from 17 to 49 years. Likewise, all women residents aged 15 to 49 years who had potentially been exposed to the intervention (8078) were registered in the monitoring database. Registered households were visited at least once every two months, during which the Community Organiser updated the case record for each registered member.

### **6.7.2 Qualitative sampling**

I used the quantitative results of the trial dataset analysis and the intervention monitoring database to identify individual women for qualitative interview based on their social, economic, and demographic characteristics, and their choice of prenatal and delivery care provider. Using the monitoring database restricted the qualitative sample to women in intervention areas, but was more precise because it identified the names of the individual health facilities they had attended. Selection criteria for the qualitative data collection included married women aged 18 and over who were currently pregnant or had given birth (at home or in a health facility) in the preceding two years. This was to include participants who had experience of maternity and the health care-seeking process (prenatal, delivery, or both).

I drew up an initial sample of 24 women who had given birth in the public or private sector in the previous two years, and invited them to participate in a focus group discussion. I then used two sets of variables to purposively sample further participants: socio-economic and demographic characteristics and health care utilisation (uptake and choice of provider). For this, I reviewed the quantitative data for descriptive patterns of health service uptake and choice of health care provider for prenatal and delivery care according to different socio-economic and demographic variables. Since the baseline data were anonymous, I turned to the intervention monitoring database to identify individual women whose background characteristics and health-seeking behaviours matched the variables. The aim was to ensure the participation of women from a range of backgrounds and health care utilisation. Since the focus of the grounded theory was on process rather than individuals, this was appropriate because it allowed us to compare care-seeking incidents and activities across socio-economic and demographic groups (Stern, 1980).

After developing an initial conceptual coding structure, I began to sample participants on the basis of emerging themes and theoretical concepts. The aim was to identify respondents who could help elucidate our conceptual understanding of health care-seeking behaviour and patterns of health care utilisation. I tried to incorporate maximum case sampling to capture the full range of behaviours, and ‘deviant’ cases; for example, women from poor socio-economic groups who had paid to have maternity care in the private sector.

## **6.8 Data collection**

### **6.8.1 Quantitative data**

The quantitative data were recorded in two datasets in the SNEHA Centres trial: the baseline census and the intervention monitoring database. Baseline data collection took 18 months to complete, from September 2011 to March 2013. Each of 40 clusters included approximately 600 households. A baseline data collection team comprising two groups of six interviewers and one supervisor were assigned equal numbers of control and intervention areas. Interviewers visited every household in each cluster sequentially and established whether a married woman aged 15 to 49 years lived there. If any women ordinarily lived in the household but were absent, up to two further attempts were made to visit them. If no eligible women lived there, or none could be located after three visits, another adult in the household was asked to participate in the census.

I worked with Prof. David Osrin to develop a baseline census for the SNEHA Centre. Census data were collected electronically on Samsung smartphones running the Android operating system ([www.android.com](http://www.android.com)) and installed with open-source electronic data collection software, Open Data Kit (ODK: [www.opendatakit.org](http://www.opendatakit.org)). I designed an electronic data collection form with text and numerical fields, single- and multiple-select responses, and built-in skips and validation constraints to minimise data entry error (see, Figures 6.3 and 6.4), and Appendix E for sample screenshots, and Appendix F for the complete form design). Questions were then translated into Hindi. Interviewers began by recording household GPS coordinates and enumerating members of each household. They then collected information about household occupants, including their socio-economic and demographic

characteristics, the maternity history of women of reproductive age, their use of health services, use of family planning methods, infant nutrition and immunization, and children's anthropometry. Data were encrypted using an encryption function within ODK before interviewers sent completed forms electronically to a secure ODK Aggregate cloud server via the phone's 3G internet connection. Data were periodically downloaded to a password-protected SNEHA desktop PC for checking and analysis.

SNEHA Community Organisers also collected ongoing intervention monitoring data on the same smartphones, using Dimagi Commcare ([www.commcarehq.org](http://www.commcarehq.org)), a similar application to ODK which allows storage and updating of electronic case records. Community Organisers registered every household in their cluster and all women aged 15-49 and children under five years. They recorded each woman's maternity history and her children's ages, her current pregnancy status, uptake and location of prenatal care for her most recent pregnancy, the location of delivery (Mumbai or outside; home or institutional birth), delivery institution, uptake and source of family planning methods, as well as information on infant feeding and child immunization.

**Figure 6.3. SNEHA Centre baseline census: question on location of delivery in English and Hindi**

The figure displays two side-by-side screenshots of a mobile application interface, likely for data collection. Both screens show the same question in English and Hindi. The English version asks: "Was the baby born in a health facility or at home?" with options "Facility" (selected) and "Home". The Hindi version asks: "आपके बच्चे का जनम घर या अस्पताल में हुआ ?" with options "अस्पताल" (selected) and "घर".

**English Version:**

ODK Collect >... Baby information (1) > Baby information group

Was the baby born in a health facility or at home?

☒ Facility

☐ Home

**Hindi Version:**

ODK Collect >... Baby information (1) > Baby information group

आपके बच्चे का जनम घर या अस्पताल में हुआ ?

☒ अस्पताल

☐ घर

**Figure 6.4. SNEHA Centre baseline census: question on site of institutional delivery in English and Hindi**

The figure displays two side-by-side screenshots of a mobile application interface, likely for data collection. Both screens show the same question in English and Hindi. The English version asks: "At which facility did the delivery happen?" with options "BMC maternity home", "BMC hospital" (selected), "Private hospital", "Government hospital", and "Urban health centre". The Hindi version asks: "आपके बच्चे का जनम कौन से अस्पताल में हुआ ?" with options "बीएमसी प्रसूति घर", "बीएमसी अस्पताल" (selected), "प्राइवेट अस्पताल/प्रसूति घर", "सरकारी अस्पताल", and "अर्बन हेल्थ सेंटर".

**English Version:**

ODK Collect >... Baby information (1) > Baby information group

At which facility did the delivery happen?

☐ BMC maternity home

☒ BMC hospital

☐ Private hospital

☐ Government hospital

☐ Urban health centre

**Hindi Version:**

ODK Collect >... Baby information (1) > Baby information group

आपके बच्चे का जनम कौन से अस्पताल में हुआ ?

☐ बीएमसी प्रसूति घर

☒ बीएमसी अस्पताल

☐ प्राइवेट अस्पताल/प्रसूति घर

☐ सरकारी अस्पताल

☐ अर्बन हेल्थ सेंटर

### **6.8.2 Qualitative data**

Qualitative data collection comprised a series of focus group discussions and semi-structured interviews. I developed a series of topic guides (Appendices G and H) adapted them to different types of participant groups: women who had delivered in a health facility, women who had delivered at home, and currently pregnant women (primiparous or multiparous). The two research assistants reviewed them for content and structure, and gave suggestions to improve them. The topic guides included short quantitative sections on the participant's background, including age, place of origin, family structure) and qualitative questions covering experiences of pregnancy and childbirth, choice of location and type of maternity care, selection of provider, and experiences of maternal health care.

I chose to use semi-structured topic guides for interviews because the research assistants felt more comfortable with more structured questions. Some grounded theorists (see Glaser, 1978, for example) suggest interviewing broadly around a general topic area. Focused questioning can lead participants to talk about what the researcher is interested in rather than what concerns them (Elliott and Higgins, 2012). However, semi-structured topic guides allow for flexibility to explore research questions (Bryman, 2004). The research assistants were encouraged to ask their own questions and explore new or interesting lines of enquiry with participants. Because we were a multidisciplinary team, our different professional and cultural backgrounds and knowledge helped prevent us from imposing our individual ideas during interviews from one discipline. Our aim was to identify and explain a practical problem as defined by its importance to the study participants (Becker, 1998: 120).

Although any type of data can be used in grounded theory (Glaser, 1978, Glaser, 1992), qualitative interviews are most often the main source. This is because the data produced lend themselves to the development of concepts and categories. I chose to begin with focus groups to get a broad sense of some of the women's main concerns and behaviours related to maternity care during pregnancy and delivery. Focus groups are suited to grounded theory, as are informal conversations, group feedback, or other activities that yield data. They can generate knowledge about social and

psychological processes and promote the sharing of common or diverse social and cultural knowledge through stories and experiences (Hughes and DuMont, 2002). They also provide an opportunity for researchers to observe social interaction among participants. When conducted well, the dialogue among participants generates most of the information. Focus groups can also enhance disclosure: people are more likely to reveal what they really think and feel when they are in comfortable and non-judgemental situations (Krueger and Casey, 2000). However, if the topic of discussion is culturally sensitive, as is the case with reproductive health, familiarity with other group members can sometimes be a barrier to self-disclosure and active participation of some group members.

Qualitative data collection continued for six months between March and August 2013, and ceased when the data were sufficient to develop the emergent concepts and themes. Overall, we conducted seven focus groups with 56 married women (an average of eight per group), 18 semi-structured interviews, one focus group discussion with five SNEHA Community Organisers, and an interview with the mother-in-law of two primigravid participants (see Appendix I for a list of data collection activities). In total, 75 women residents in nine trial intervention clusters and five SNEHA's Community Organisers participated. Focus group discussions were held in the SNEHA Centre allocated to the cluster where participants lived. Semi-structured interviews took place in the participant's home or, if this was not possible, in the nearest SNEHA Centre. All interviews were conducted in Hindi or Marathi and lasted from 30 minutes to more than an hour.

Qualitative interviews and focus groups were digitally recorded and transferred to a password-protected computer. Each was allocated a unique code following a predefined format (see Table 3). For example, the final interview (SSI-18) at SNEHA's research site ('n') in the qualitative phase ('b'), was with a woman who had delivered ('de') in a health facility ('d') in the public sector ('pu'), whose interview was conducted in Hindi ('hin') and was the fourth of this type ('0004'). Therefore, the interview code was nbddedpuhin0004.



**Table 3. Format for allocating unique codes to qualitative data**

1 <sup>st</sup> character	SNEHA research site: n
2 <sup>nd</sup> character	Phase of research: b
3 <sup>rd</sup> and 4 <sup>th</sup> characters	Type of participant Community Organiser: co Currently pregnant: cp Delivered a baby: de Mother-in-law: ml
5 <sup>th</sup> character	Maternity care history No prenatal care: n Prenatal care: a Home birth: h Institutional delivery: d
6 <sup>th</sup> and 7 <sup>th</sup> characters	Site of maternity care Home: br Public: pu Private: pr Mix of public and private sectors: pp
8 <sup>th</sup> – 10 <sup>th</sup> character	ISO 639-3 code for language of transcript
11 <sup>th</sup> to 14 <sup>th</sup> characters	four digit sequential ID number

The research assistants prepared verbatim transcriptions of their own interviews and translated them into English in Microsoft Word 2007 ([www.microsoft.com](http://www.microsoft.com)). We agreed on a format for transcribing to ensure uniformity. Accuracy of transcription and translation was checked by selecting random sections of each other's transcripts and cross-checking them with the original audio recording. The English transcripts were then imported into folders in NVivo, one for focus groups and another for interviews. I constructed a classification table containing each participant's socio-economic and maternal information collected at the start of each focus group and interview. I entered values for socio-economic and demographic variables (age group, education, religion, parity, and time living in the current area) and maternal health service utilisation (uptake of institutional prenatal care, delivery care, and the type of provider visited) (Appendix J). I then created a case node for each participant to allow comparative analysis across cases, such as age group or educational attainment. Unfortunately, the research assistants failed to collect socio-economic and maternity information from participants in the first two focus groups (FGD-1 and FGD-2).

As data collection progressed, the research assistants' interviewing skills and confidence improved, and participants became more comfortable sharing their maternity experiences. Interviews started to resemble informal discussions rather than a formal and structured data collection exercise (see Box 2 below for an example).

**Box 2. Excerpt from fieldnotes reflecting on a semi-structured interview**

*Follow-up interview with a 19-year-old Muslim woman, registered for her first delivery at a municipal hospital.*

Unlike most of the interviews, where I would ask questions and the respondent answer, this interview felt more like a conversation. Not only did the respondent answer my questions, she also asked me questions in return. She expressed her fears and revealed personal matters about herself. She also asked me questions about my personal life. She talked about her fear of being pregnant for the first time, shared her worries about her financial situation, and even discussed issues relating to her own sexuality. Like the last time I talked to her, she had a number of questions relating to sexual intercourse during pregnancy, which I answered to the best of my abilities. This give-and-take of information from both sides helped build rapport and open dialogue: the respondent confessed that she was 19 – not 21 as she had reported during our last meeting. Throughout the interview, she often referred to our conversation as an opportunity in which she could talk to a friend because she could ask me questions that she could not ask anyone else.

Since maternity care usually involves repeated cycles of contact with the health care system and repeated experiences of delivery care, follow-up with the same women would have been ideal. However, in the absence of resources for a longitudinal study, we asked primiparous women about their current and future anticipated behaviours, and asked other women about their most recent and previous experiences of prenatal and delivery care.

## **6.9 Data analysis**

### **6.9.1 Quantitative analysis**

#### **6.9.1.1 Dependent variables**

The quantitative analysis involved identifying determinants of uptake of prenatal and institutional delivery care with different levels of public and private provider. Prenatal care was defined as receiving three or more consultations with a health care

provider (International Institute for Population Sciences and Macro International, 2007), the local recommendation at the time of the study. Public sector facilities providing prenatal services included municipal health posts, urban health centres, maternity homes, general hospitals, and tertiary hospitals. Larger state government general hospitals that provide free or low-cost services were also included in the tertiary group. The private sector included individual practitioners providing outpatient services, maternity clinics with inpatient centres, and larger hospitals. For public-sector facilities, delivery services were available everywhere except in health posts, while all private providers except individual practitioners offered delivery services.

#### ***6.9.1.2 Independent variables***

The independent variables selected for the quantitative analysis were chosen to reflect socio-economic position in the baseline dataset, including a household asset index, maternal education, maternal age, parity, residence, duration of residence (as a proxy for familiarity with health care alternatives), and faith (religion). These variables were selected because they are commonly cited in the health care literature in low resource settings as significantly associated with patterns and determinants of health care utilisation. I examined these in some detail in chapter three. They also reflect the results of previous work I have been involved in with similar populations in Mumbai's informal settlements (Shah More et al., 2009a, Shah More et al., 2011, Shah More et al., 2009b).

##### ***Household asset quintile***

Measuring individual or household wealth in low-income settings is difficult because people are often engaged in irregular or informal employment and have poor access to bank accounts. An alternative method is to collect information on the physical assets in each household (Glennerster and Takavarasha, 2013). This is commonly used as a way of segmenting a population (in relative rather than absolute terms) through data from Demographic and Health Surveys. Principal components analysis is a statistical method that can be used to combine assets commonly possessed by household into a unidimensional index (Vyas and Kumaranayake, 2006). Using this method, socio-economic position was described by calculating quintiles of the asset index. Assets included home ownership, possession of a ration card (indicating that

the household was registered as below the poverty line), housing material, private water supply, private toilet, finished floor, and possession of a mattress, pressure cooker, gas cylinder, stove, bed, table, clock, mixer, telephone, refrigerator, or television.

### *Maternal education*

Education in India is provided through public and private institutions. The education system comprises pre-school (up to 5 years), primary (Classes 1 to 5, aged 6 to 10 years), upper primary (Classes 6 to 8, aged 11 to 14 years), secondary (Classes 9 to 10, aged 14-16 years), and higher secondary (Classes 11 to 12, aged 16-18 years). Education is also provided through Islamic schools called Madrasas.

Along with household socio-economic status, mothers' education has been associated with maternity care uptake in India (International Institute for Population Sciences and ICF, 2017). It was included in the analysis as an ordered categorical variable, coded as none, primary, secondary, or higher than secondary.

### *Maternal age*

Young age at marriage and childbirth is a major contributor to maternal and child mortality in India (Ministry of Health and Family Welfare, 2013a). In this analysis, maternal age measured the mother's age in years at the time of data collection and was coded as a continuous variable.

### *Parity*

As described in the literature review in Chapter 3, there is some evidence in that higher parity women tend to have a lower uptake of institutional maternity care and greater odds of home birth than primiparous women (Das et al., 2010, Ghosh-Jerath et al., 2015, Hazarika, 2010, Singh et al., 2012, Yadav and Kesarwani, 2015). Parity was measured as a continuous variable representing the total number of births, which included the index pregnancy in the previous two years.

### *Duration of residence*

Mumbai has had a long and varied experience of migration, most recently as a destination for migrants from northern states such as Uttar Pradesh (Bhagat and

Jones, 2013). Relocating has an impact on people's living conditions, social networks, and access to health care. We wanted to assess the relationship between how long women had lived in their current location and their patterns of health care utilisation. Duration of residence was recorded as a continuous variable representing the number of years the woman had been living in Mumbai.

### *Religion*

Religious beliefs often have an important influence over reproductive and health behaviour. The dominant faith among the respondent population was Islam, with Hinduism and other faiths in the minority. Therefore, religion was categorized as a binary variable describing whether the woman was Muslim or non-Muslim.

### **6.9.1.3 Statistical analysis**

The quantitative data were collected to evaluate the SNEHA Centre trial. Because of my limited experience using statistics, I did the analyses for this thesis with the evaluation researchers. I carried out much of the descriptive analysis and interpretation of frequency and percentage distributions, and I suggested variables to include in logistic regressions. The trial researchers conducted the regression analyses although I was involved in the interpretation of results. I was interested in understanding overall patterns of care-seeking and identifying particular patterns and behaviours to follow up on in the qualitative interviews.

The quantitative analyses included data from women who had reported a birth in the two years prior to the baseline census. SNEHA data managers downloaded and cleaned the data in Stata 12 (StataCorp, College Station, Tx: [www.stata.com](http://www.stata.com)). We summarised frequencies and percentages of prenatal care, whether it took place in the private or public sector, and use of tertiary hospitals and smaller public health facilities, against the selected independent variables. We repeated this for institutional delivery. We ran a univariable logistic regression with a random effect for cluster for each combination of dependent and independent variables: whether the woman had three or more visits to a health care provider (denominator: all women who had been pregnant in the previous two years), whether prenatal care was in the public rather than the private sector (denominator: women who had had more than three prenatal care visits), and whether it was in a large public hospital rather than a

smaller facility (denominator: women who had made more than three prenatal visits in the public sector).

For delivery, we examined whether institutional or home care was chosen (denominator: women who had delivered in the previous two years), whether she delivered in the public rather than the private sector (denominator: women who had had an institutional delivery), and whether it was in a large public hospital or a smaller one (denominator: women who had delivered in the public sector). We applied variables derived from our understanding of local determinants of care-seeking and existing studies – maternal age, schooling, and parity, household economic status, duration of residency, and religion (see, for example, Shah More et al., 2009a, Thind et al., 2008, Yadav and Kesarwani, 2015) – to two stages of statistical analysis. First, we created univariable models for each combination of dependent and independent variables; then, we created a single multivariable logistic regression model for each outcome with a random effect term for cluster (Hayes and Moulton, 2010). All models were unadjusted, then adjusted for covariates. We included age and parity in the models since the Stata *collin* package did not suggest collinearity. All models satisfied quadrature parameters.

I was interested in whether women tended to choose a particular health sector or facility and whether they sought their maternity care from specific providers. These questions have largely been ignored in health care-seeking discussions. The hypothesis was that institutional and private sector prenatal and delivery would increase with maternal education, duration of residency, and economic status.

### **6.9.2 Qualitative analysis**

In this section, I describe in some detail the qualitative analysis and the process of conceptually understanding the data to develop the grounded theory.

I began the qualitative analysis with the first completed, translated and transcribed focus group discussion. The two research assistants and I read the entire transcript separately once to gain some initial familiarity with the data. In a second reading, I highlighted words or sections that seemed interesting or that might fit a broader

narrative of maternity care-seeking, and recorded our understanding and ideas about them. I used the same pre-analysis procedure for each of the focus group transcripts.

At this stage, I was seeking an overall sense of the participants' stories, concerns and behaviours, to "prepare the ground for analysis" (Dey, 2003: 87). The process gave us a general feel for the content of women's narratives and the opportunity to reflect on underlying processes and meaning (Corbin and Strauss, 2008). Once I had gone through the pre-analysis procedures, I began to code the data. The quality of interviews and transcripts varied throughout the research. Appendices K and L give the reader a sense of the variety of quality and content of the interviews.

#### **6.9.2.1 Open coding**

I coded the qualitative focus group and interview transcripts with the two research assistants using NVivo qualitative data analysis software ([www.qsrinternational.com](http://www.qsrinternational.com)). As proposed by Saldaña (2009), we coded in cycles. Initial-cycle coding uses the simplest and most direct methods to code initial data; later cycle coding requires more analytical techniques such as abstracting, conceptualising, and theorising, necessary to reach a higher level of understanding and integration. Together, we read methodically and systematically to identify different interpretations and conceptual possibilities and avoid reducing our analysis to "an impressionistic cluster of categories" (Glaser, 1978: 58). At the same time, staying close to the data prevented us from "lapsing entirely into theoretical flights of fancy" (Charmaz, 1990: 1168).

As described above, grounded theory analysis usually involves line-by-line coding. However, because we used verbatim transcripts, this was not always practical. Verbatim transcripts reflect the language and flow of conversation of participants, and it is not always clear where sentences end and begin (Locke, 2001). This can make line-by-line coding impractical and it is not always obvious how much data need to be captured in a code (2001). As Charmaz points out, whether observed by the researcher or described by a participant, "Concrete, behavioristic descriptions of people's mundane actions may not be amenable to line-by-line coding" (Charmaz, 2006: 56). For example, Box 3 is an excerpt from a group discussion with pregnant women. The example shows how participants' words are sometimes confused and

contain pauses, repetitions, and non-verbal communication. They sometimes talk at the same time and interrupt each other. Interviewees are not always sure how to respond, can digress into other issues, and often take time to explore the meanings behind what they are saying. They may seek clarification, give short or closed responses, and stop talking or change topic abruptly.

**Box 3. Excerpt from a focus group discussion with pregnant women**

**I:** No, I am asking you that ... why are you okay with going to a government hospital in the village but not okay with going to a government hospital in Mumbai?

**R3:** *Arre (expresses exasperation)*, government, at both places ... wherever one ... wherever one ... it happens ... I mean, when he (points to the child on her lap) was born, they had registered my name there [in a Mumbai government hospital] ... but he happened [was delivered] here only, at home he was born ... So the misfortune [might mean “opportunity”] did not come to go to a hospital ... I used to go like that only, to get check-ups and all...

**R6:** (Inaudible 20.58) ... the expense here is more ... In Mumbai, if one has money then there is food, if [money] is not there, then the person often thinks that, if I go to the village then it will be nice, and there won't be so much expense either...

**R3:** Expense also and ... who is there to see [take care of] me? That is why we think, let's go to the village. [There] are two people [in the village who can take care of me], my *bhabhi* (*older sister-in-law*) also stays there ... and then they look after me too. Who will see [take care of me here in Mumbai]? That is why I am going...

(R6 and R3 mumble to each other).

Some grounded theorists suggest coding from observational or summarised fieldnotes rather than transcripts (Glaser, 1978, Holton, 2007). However, conceptual analysis requires the researcher to pay attention to language and how participants use it to express themselves (Wilson, 1963). I was more comfortable coding full, verbatim transcripts. Since grounded theory considers incidents the unit of analysis (Glaser, 1992), coding should allow a degree of researcher subjectivity, not only about what constitutes an incident but also how much to code. Provided the category assigned to a block of data captures its full variation, the researcher can decide the amount of data to be coded in each category (Gibson and Hartman, 2013).

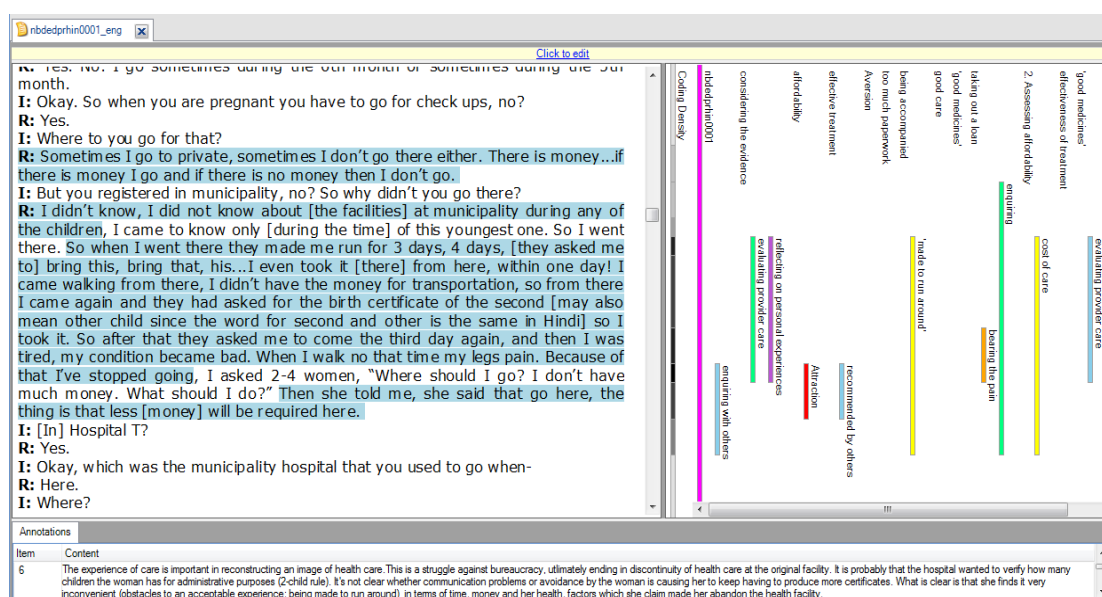
The critical point seems to be that the researcher conceptualises and codes a full range of analytical ideas, incidents, and their properties until saturation. Whenever we identified an incident in the data that seemed relevant to the substantive area, we



stopped and discussed the multiple implicit and explicit potential meanings by asking questions typical of the grounded theory method: “What are these data a study of?” “What category, or property of a category, of what part of the emerging theory, does this incident indicate?” and, “What is actually happening in the data?” (Charmaz, 2006, Glaser, 1978: 57, Strauss and Corbin, 1990). Remaining open to all analytical possibilities often required long discussions about how to code the data. This benefited the analysis because it forced us to consider alternative interpretations, although it was inevitably influenced by the research questions and the research team members’ background experience and personal or professional interests.

The analytical codes focused on the process of health care decision-making and choice of provider, and women’s experiences of using health care services. Figure 6.5 is an excerpt from an interview transcript and associated coding in Nvivo. The coloured stripes in the right-hand panel are the codes applied to the matching sections of the text in the left-hand panel. As the figure indicates, the codes captured both small and broad sections of data, and more than one code could apply to the same piece of data. Also evident are different types of coded data, including action and process (‘enquiring with others’, ‘evaluating provider care’), determinants (‘cost of care’), and *in vivo* codes that captured participants’ own words (‘made to run around’).

**Figure 6.5. Example coding of a qualitative interview transcript using Nvivo**



As I created each new code, I recorded its meaning and scope in a qualitative codebook (see Appendix M for an early example). I periodically distributed an updated codebook to the research assistants to ensure consistent coding.

At this point, I faced some difficulties. Firstly, because open coding involves intensive analysis and simultaneous labelling of data to reflect multiple meanings and interpretations, early analysis had generated a large number of codes (Holton, 2007, Strauss and Corbin, 1990). During open coding of the first three focus groups, I had created around 140 codes. Therefore, I decided to filter and refocus them. In grounded theory, the researcher is not required to consider all possible data, but only those sufficient to reach saturation of concepts; that is, where new information ceases to add to theory development (Glaser and Strauss, 1967, Pascale, 2011, Strauss and Corbin, 1990). I reviewed each code in turn, re-examining the essential features in relation to our emerging understanding and developing theory. I renamed or removed codes that were poorly defined or did not seem to relate closely to the research area. I created a “side-lined codes” folder to store vague or superfluous codes in case the direction of the research changed later on.

Secondly, many of the codes were descriptive, a common problem for inexperienced grounded theorists (Holton, 2007, Urquhart, 2001). There is an important difference between coding for descriptive analysis and for conceptual understanding. Whereas descriptive codes usually repeat or summarise a single event or section of text, conceptual codes are more abstract and allow similar phenomena to be grouped conceptually into categories (Urquhart, 2012). At times, I found it difficult to conceptualise indicators and events in terms of abstract ideas, in part because of my medical anthropology background and inclination towards ‘thick description’. This resolved as my ability to think in more abstract ways improved and as conceptual categories became developed and integrated (see 5.9.2.2).

#### ***6.9.2.2 Developing and integrating categories***

The conceptual categories I developed for the theory derived mainly from the coding of qualitative focus groups and interviews, rather than the quantitative data. As outlined in section 5.1, the quantitative findings on care-seeking patterns and

determinants provided information to purposively sample specific cases and follow up in qualitative interviews.

Later in the analysis, I considered ways of grouping open codes into broader, more abstract analytic categories. Analytical abstracting involved comparing women's accounts of their circumstances, reasons for using health care and utilising specific providers, and their care-seeking experiences. I compared data within cases and with previous cases and applied new data to existing categories to test for fit and adequacy and to develop the properties of the category (Charmaz, 1990, Glaser, 1978). To an extent, I had already categorised relationships among some data during open coding, but many individual codes remained uncategorised. I re-conceptualised and recoded many of them to reflect the dynamic process of choosing and seeking health care, raising the data to a theoretical level (Glaser, 1978: 55). Some abstract categories emerged as a result of grouping similar codes, while other, more abstract open codes were raised to higher-level categories. For example, I renamed the open code 'enquiring with others' (Figure 6.5) as a conceptual category 'enquiring', which I then used to group other open codes relating to the process of enquiring about health care providers.

### **6.9.2.3 *Writing memos***

I kept memos of my evolving theoretical understanding of the data and the meaning of emerging concepts. Appendix N (i) is an early memo recording my thoughts on an early process prior to accessing health care, which I called exploring the options. Appendix N (ii) shows a more theoretically developed memo in which I define a central conceptual process called purposive selection, including the conditions in which it occurred, the variables that intervened to modify the process, and the outcomes of the process.

I also wrote methodological memos about our fieldwork experience, interaction with participants, and reflections on the application of grounded theory methods. They were useful for identifying questions we had asked that were potentially leading, or gaps in information that could be improved in subsequent interviews. In addition, I made reflexive footnotes on each transcript using the annotations feature in NVivo, with clarifications of participants' language, information about the interview or

fieldwork context, and with analytic notes about the case. Annotations helped add practical and interpretive detail to each case, which were important when reviewing transcripts for conceptual development and clarifications later on.

#### **6.9.2.4 *Delimiting the theory***

As my conceptual understanding of the actions and processes underlying women's care seeking improved, I developed more abstract codes as potential core categories. Examples included 'tailoring choices', 'reconstructing', and 'purposive selection'. I tested each one for fit and work as a core category by relating it to an analytical storyline (Strauss and Corbin, 1990). Although most adequately explained part of the theory, they all failed to explain enough variation to merit selection. Some were dropped while others became major categories (e.g. 'reconstructing', and 'purposive selection'). One – manoeuvring – seemed to fit. It appeared as a frequent and stable occurrence in much of the data, and also seemed to connect many of the other categories (Gibson and Hartman, 2013). At this point, I selected it as the core category.

Once the core category had been identified, I constructed a conceptual framework that reflected the hierarchical structure of the major categories and subcategories. I also used simple diagramming techniques using the free version of XMind mind mapping software ([www.xmind.net](http://www.xmind.net)) to visualise each of the major categories and their subcategories (see Appendix O for an example). Using the software allowed the order and structure of concepts and relationships to be easily modified.

### **6.10 Reflexivity and research**

Researcher reflexivity has become an important issue in discussions of quality. Positioning the researcher within the research by explaining the processes followed, and his or her experiences, decisions, and interpretations, reduces the imposition of preconceived ideas by keeping the researcher aware of personal assumptions and interpretations, as well as those of the research participants. It also gives readers the opportunity to assess how these issues may have influenced the reporting of findings (Charmaz, 2006).

While recognising that these potential pitfalls exist, they do not prevent the researcher from identifying participants' major concerns and the ways they handle them. Systematic constant comparison and testing the fit of conceptual categories can help ensure that the theory is not constructed from preconceived understandings or professional bias. The rigorous qualitative researcher or grounded theorist does not look for what he or she wishes to find, but rather strives to uncover, from an emic perspective, what is in the research setting.

As mentioned in the preceding sections, I was aware of the potential influence of my personal and professional background and previous experience, my relationship with my co-researchers and the participants, and the relationship between the participants and SNEHA as a local provider of health information and services on the research data and the interpretation and reporting of them. The research setting undoubtedly influenced the ways in which I understood women's narratives, as well as my own and my colleagues' interpretations of them, the types of concepts I used to represent them, and the relationships I saw between them when trying to explain what was going on. Concepts used at any given time and place are brought into play because of their usefulness in representing a constructed understanding and experience of reality at the time: "The nature of the conceptual system that is invoked depends upon the needs of the individual at that moment." (Jaccard and Jacoby, 2010: 15). I was aware of the risk of biasing the theory with my own experiences of health care in Mumbai, many of them negative (long queues, bureaucratic admission procedures, and poor communication). I considered my own experiences as "the difference between knowledge of something and acquaintance with the phenomenon" (quoted in Van Maanen, 1988: 18).

There is no easy or agreed-upon solution to how much one can identify and resist these influences, since the researcher cannot ignore or completely set aside his or her preconceived values, beliefs, and knowledge. However, an awareness of them can help challenge them, and this can be reinforced through systematic comparative methods and reflexive memo-writing.

In the following chapters seven and eight, I present the findings of the quantitative and qualitative analyses.

## Chapter 7 Quantitative results

Data for the quantitative analysis came from 3848 women who had given birth within the two years prior to the SNEHA Resource Centre trial baseline census and resided in 40 informal settlements of Mumbai's eastern L and M East municipal wards. Table 4 presents background information on the women who participated in the census.

**Table 4. Characteristics of 3848 women respondents in 40 informal settlement areas in Mumbai who had delivered in the two years preceding the census**

	Respondents	(%)
<b>Maternal education</b>		
None or informal	1170	(30)
Primary	236	(6)
Secondary	2144	(56)
Higher	297	(8)
Missing	1	(<1)
<b>Household asset quintile</b>		
Quintile 1	771	(20)
Quintile 2	769	(20)
Quintile 3	785	(20)
Quintile 4	758	(20)
Quintile 5	765	(20)
<b>Duration of residency in Mumbai</b>		
Less than 1 year	260	(7)
1-4 years	867	(22)
5-9 years	561	(15)
10 years or more	2160	(56)
<b>Age</b>		
Under 20	139	(3)
20-29	2841	(74)
30-39	804	(21)
40-49	64	(2)
<b>Parity, including index delivery</b>		
1	1168	(30)
2	1009	(26)
3	765	(20)
4	413	(11)
5 or more	493	(13)
<b>Religion</b>		
Muslim	3184	(83)
Hindu	651	(17)
Other	13	(<1)
All	3848	(100)

More than half (56%) had completed secondary education, while 30% either had no schooling or had received an informal education. More than half (56%) had lived in Mumbai for at least a decade. Three-quarters were between 20 and 29 years. Most participants (83%) were Muslim, followed by Hindus (17%).

Table 5 and Figure 7.1 below, summarise information on institutional maternity care by selected maternal and household socio-economic and socio-demographic characteristics (selection was explained in section 6.9.1.2). The table describes uptake and site of prenatal care in the public and private sectors in Mumbai. Uptake of institutional prenatal care was high: 94% of women had received at least three prenatal consultations. Large public facilities were the most common source of maternity care: 49% of women chose to have their prenatal care at a municipal or government tertiary hospital. The use of smaller municipal maternity hospitals and urban health centres was less common (14%). Around one-third of all women chose the private sector for their prenatal care.

Patterns of institutional prenatal care indicated that women from lower socio-economic groups utilised less prenatal care than others. Women who were uneducated (12%), in the lowest household asset quintile (15%), had lived in Mumbai for less than one year (24%), and had five or more births (13%), had low uptake of prenatal care (fewer than three prenatal visits). Use of tertiary public hospitals was more common among women under thirty and with lower parity, but lower among the least poor. A higher proportion of more educated and least poor women chose to use private sector facilities for their prenatal care (45% and 46%, respectively), while it was less common among women under 20 (22%). More Muslim women chose the private sector (33%).

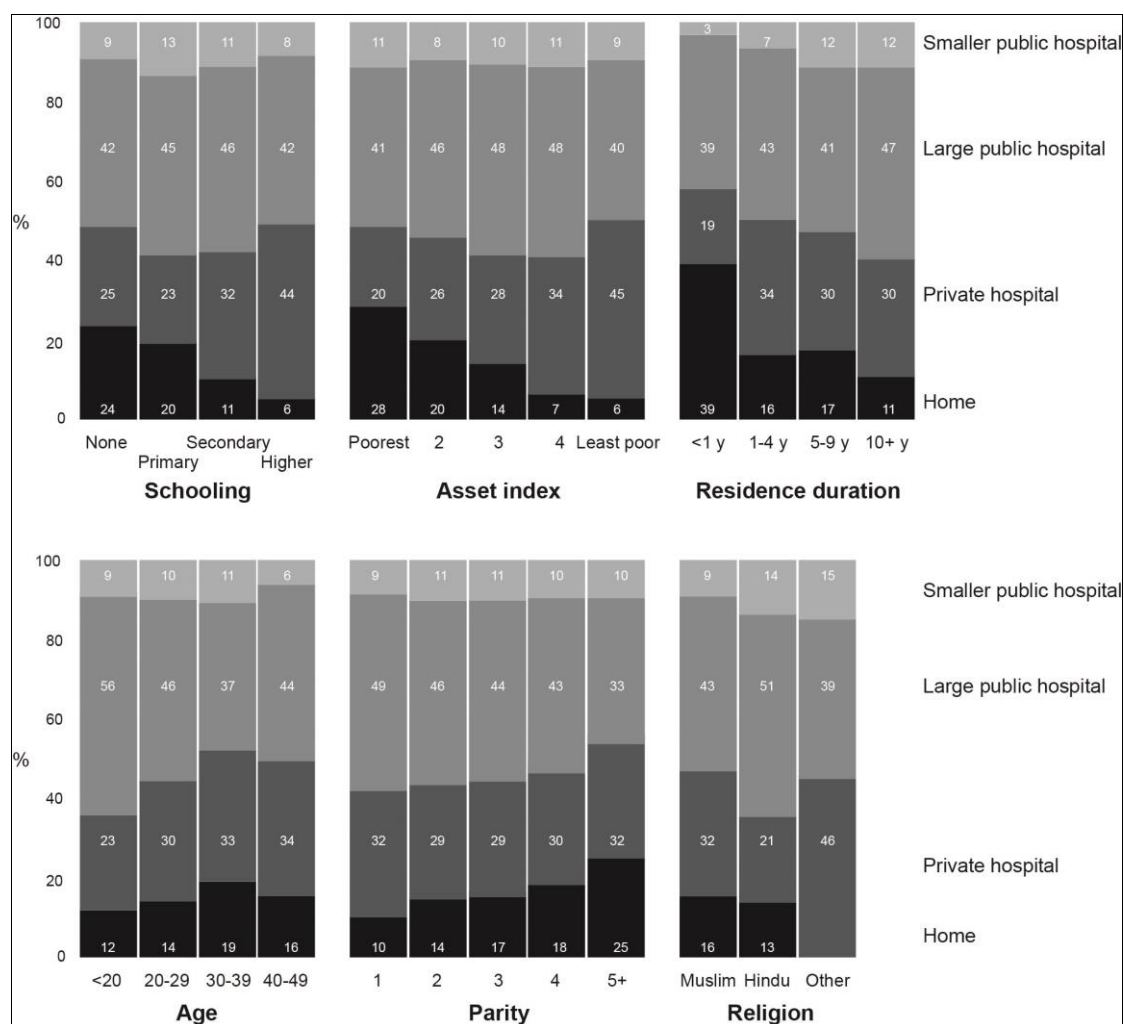
**Table 5. Prenatal care site, by maternal characteristics, for 3819 deliveries in the two years preceding the census**

	Total n (%)	<3 prenatal care visits n (%)	Prenatal care in private sector n (%)	Prenatal care in public sector	
				Prenatal care at tertiary public hospital n (%)	Prenatal care at smaller public facility n (%)
<b>All</b>	<b>3819 (100)</b>	<b>242 (6)</b>	<b>1160 (31)</b>	<b>1880 (49)</b>	<b>537 (14)</b>
<b>Maternal education</b>					
None or informal	1158 (100)	137 (12)	300 (26)	562 (49)	159 (14)
Primary	234 (100)	14 (6)	54 (23)	124 (53)	42 (18)
Secondary	2130 (100)	89 (4)	672 (32)	1065 (50)	304 (14)
Higher	297 (100)	2 (1)	134 (45)	129 (43)	32 (11)
<b>Household asset quintile</b>					
Quintile 1	765 (100)	114 (15)	152 (20)	377 (49)	122 (16)
Quintile 2	764 (100)	60 (8)	199 (26)	407 (53)	98 (13)
Quintile 3	772 (100)	37 (5)	225 (29)	395 (51)	115 (15)
Quintile 4	755 (100)	19 (3)	234 (31)	393 (52)	109 (14)
Quintile 5	763 (100)	12 (2)	350 (46)	308 (40)	93 (12)
<b>Duration of residency in Mumbai</b>					
Less than 1 year	258 (100)	61 (24)	63 (24)	115 (45)	19 (7)
1-4 years	864 (100)	67 (8)	296 (34)	399 (46)	102 (12)
5-9 years	557 (100)	35 (6)	173 (31)	262 (47)	87(16)
10 yrs or more	2140 (100)	79 (4)	628 (29)	1104 (52)	329 (15)
<b>Age</b>					
Under 20	139 (100)	4 (3)	31 (22)	86 (62)	18 (13)
20-29	2823 (100)	166 (6)	846 (30)	1427 (50)	384 (14)
30-39	795 (100)	67 (8)	263 (33)	338 (43)	127 (16)
40-49	62 (100)	5 (8)	20 (32)	29 (47)	8 (13)
<b>Parity</b>					
1	1163 (100)	51 (4)	373 (32)	597 (51)	142 (12)
2	1007 (100)	49 (5)	297 (29)	518 (52)	143 (14)
3	758 (100)	53 (7)	217 (29)	372 (49)	116 (15)
4	405 (100)	26 (7)	123 (30)	195 (48)	61 (15)
5 or more	486 (100)	63 (13)	150 (31)	198 (41)	75 (15)
<b>Religion</b>					
Muslim	3161 (100)	198 (6)	1041 (33)	1523 (48)	399 (13)
Hindu	645 (100)	44 (7)	114 (18)	352 (54)	135 (21)
Other	13 (100)	-	5 (38)	5 (38)	3 (23)

Note: Information missing for 28 women



**Figure 7.1. Delivery care site, by maternal characteristics, for 3820 deliveries in the two years preceding the study**



Note: Information missing for 28 women

Uptake of institutional delivery care was high (85%), of which 36% took place in the private sector. Of women who sought delivery care at a public health facility, over two thirds (82%) chose a tertiary hospital (data not shown). Figure 7.1 visualises choice of delivery care site across the public and private sectors. Home births were more common among less educated and poorer women, recent migrants to Mumbai, and women with five or more births. More educated and least poor women chose to use private sector health facilities for their delivery care (44% and 45%, respectively), as did Muslim women compared to Hindus (32% and 21%, respectively). Use of private health care was lower among women who had lived in

Mumbai for less than a year (19%). Tertiary public facilities were popular among women who had lived in Mumbai longer, those with fewer children, and Hindu women (51%).

Table 6 summarises the results of univariable and multivariable logistic regression models and explores the association of selected maternal and household socio-economic and socio-demographic characteristics with uptake of prenatal and delivery care, choice of public or private sectors, and delivery at tertiary public hospitals. Here, I report the significant results from the adjusted model (adjusted odds ratio: aOR) at the 95% confidence interval (CI) level.

Education, household economic quintile, and duration of residency in Mumbai were positively associated with receipt of three or more prenatal visits. The adjusted odds of making three or more prenatal care visits increased by 1.08 for each additional year of maternal education (95% CI 1.04, 1.13). Women from wealthier households were significantly more likely to have institutional prenatal care than women from poorer households (aOR 1.92 (95% CI: 1.59-2.32)). Uptake was negatively associated with parity (aOR 0.79 (95% CI: 0.72, 0.88)). Similar patterns were observed with uptake of institutional childbirth. For example, the adjusted odds of institutional delivery increased by 1.07 (95% CI 1.04, 1.10) for each additional year of maternal education. Women from wealthier households were 1.62 (95% CI: 1.43-1.83) times more likely to deliver in a health facility than poorer women. The adjusted odds of receiving prenatal delivering in the public sector

Among women who chose institutional maternity care, the odds of having prenatal and delivery care at a private sector facility increased with education, household asset quintile, age, and shorter duration of residency in Mumbai. With each increase in educational level, the adjusted odds of seeking public sector prenatal care was 0.96 (95% CI 0.94, 0.98). Women who had lived in Mumbai longer were slightly more likely to use public sector prenatal care (aOR 1.02 95% CI 1.01, 1.03). Muslim women were half as likely to choose a public hospital both for prenatal care (aOR 0.51 (95% CI: 0.39, 0.67)). Adjusted odds ratios for public sector delivery care were almost identical to prenatal care.

Within the public sector, women were less likely to use a tertiary hospital for prenatal care if they had higher parity (aOR 0.87 95% CI: 0.80-0.95) and for delivery care if they had lived in Mumbai longer (aOR 0.98 95% CI: 0.97-0.99) and had higher parity (aOR 0.84 95% CI: 0.76-0.93).

The findings of the quantitative analyses raise several important points. Firstly, they show the complexity of patterns of maternity care uptake and choice of provider. They suggest that, overall, uptake of institutional prenatal and delivery care is high in informal settlements of Mumbai. There is a reasonably clear impression that the more educated a woman is and the wealthier her household, the more likely she is to have prenatal care and institutional delivery. This is also associated with having lived in the city for longer. However, women who already had children were less likely to make use of these services, as were women of Islamic faith.

Although there is demand for private sector maternity care, utilisation of the public sector is high. Moreover, within the public sector, large public hospitals are heavily utilised; a much lower proportion of women seek prenatal and delivery care at smaller health facilities. These smaller facilities are numerous and are distributed across the city, with the aim of improving access for poor or socially isolated communities including informal settlements. However, it appears that a substantial proportion of women bypass them in favour of larger hospitals, often further away. Furthermore, despite their higher costs, a substantial minority of women from lower socio-economic backgrounds seek prenatal and delivery care with private providers.

The adjusted odds models indicate significant inequalities in patterns of uptake, access to the private sector, and utilisation of different levels of health care across socio-economic and demographic groups. Similar to uptake, women who are younger, more educated, and less poor, have significantly greater odds of seeking maternity care in the private sector. These findings generally accord with the results of the studies I reported in the literature review (Chapter 3) and reflect broad patterns of health care inequities among socially and economically marginalised groups across urban and rural India.

**Table 6. Odds ratios for uptake of prenatal care and institutional delivery, care in the public sector, and care at tertiary public hospitals, in the two years preceding the study, by maternal characteristics.**

	Prenatal care		Delivery care	
	OR (95% CI)	aOR (95% CI)	OR (95% CI)	aOR (95% CI)
	<b>3 or more prenatal care visits</b> (reference: <3 visits)		<b>Institutional delivery</b> (reference: home delivery)	
Maternal schooling (y)	1.17 (1.13, 1.22)	1.08 (1.04, 1.13)	1.13 (1.10, 1.16)	1.07 (1.04, 1.10)
Household asset quintile	2.46 (2.08, 2.90)	1.92 (1.59, 2.32)	1.95 (1.75, 2.18)	1.62 (1.43, 1.83)
Duration of residency (y)	1.06 (1.04, 1.08)	1.05 (1.03, 1.07)	1.04 (1.03, 1.05)	1.03 (1.02, 1.04)
Age (y)	0.96 (0.93, 0.98)	1.01 (0.97, 1.05)	0.96 (0.95, 0.98)	1.01 (0.98, 1.03)
Parity	0.81 (0.76, 0.86)	0.79 (0.72, 0.88)	0.84 (0.80, 0.88)	0.82 (0.76, 0.89)
Muslim faith	1.06 (0.72, 1.56)	1.11 (0.74, 1.66)	0.87 (0.65, 1.15)	0.90 (0.67, 1.21)
	<b>Prenatal care in public sector</b> (reference: private sector)		<b>Delivery in public sector</b> (reference: private sector)	
Maternal schooling (y)	0.96 (0.94, 0.97)	0.96 (0.94, 0.98)	0.96 (0.94, 0.98)	0.96 (0.94, 0.98)
Household asset quintile	0.72 (0.66, 0.79)	0.70 (0.63, 0.77)	0.73 (0.67, 0.80)	0.71 (0.64, 0.78)
Duration of residency (y)	1.01 (1.00, 1.02)	1.02 (1.01, 1.03)	1.01 (1.00, 1.01)	1.02 (1.01, 1.03)
Age (y)	0.98 (0.96, 0.99)	0.94 (0.92, 0.96)	0.97 (0.96, 0.99)	0.96 (0.93, 0.98)
Parity	0.99 (0.95, 1.04)	1.04 (0.97, 1.11)	0.96 (0.91, 1.00)	0.98 (0.92, 1.05)
Muslim faith	0.58 (0.45, 0.75)	0.51 (0.39, 0.67)	0.63 (0.49, 0.81)	0.58 (0.45, 0.75)
	<b>Prenatal care at tertiary public hospital</b> (reference: other public facility)		<b>Delivery at tertiary public hospital</b> (reference: other public facility)	
Maternal schooling (y)	1.02 (0.99, 1.05)	1.01 (0.98, 1.04)	1.01 (0.98, 1.04)	1.01 (0.97, 1.04)
Household asset quintile	1.02 (0.91, 1.16)	1.03 (0.90, 1.19)	1.03 (0.90, 1.18)	1.07 (0.92, 1.26)
Duration of residency (y)	0.98 (0.98, 0.99)	0.99 (0.98, 1.00)	0.98 (0.97, 0.99)	0.98 (0.97, 0.99)
Age (y)	0.97 (0.95, 0.99)	1.00 (0.97, 1.03)	0.98 (0.96, 1.01)	1.03 (0.99, 1.06)
Parity	0.88 (0.83, 0.94)	0.87 (0.80, 0.95)	0.88 (0.82, 0.95)	0.84 (0.76, 0.93)
Muslim faith	1.15 (0.87, 1.54)	1.30 (0.96, 1.76)	1.04 (0.74, 1.45)	1.20 (0.84, 1.70)

OR: odds ratio from univariable logistic regression model with random effect for cluster.

aOR: adjusted odds ratio from multivariable logistic regression model, including the other independent variables and random effect for cluster. CI: confidence interval. y: years.

The finding that Muslim women are twice as likely to seek prenatal and delivery care with a private provider as Hindu women is striking. Interestingly, there appears to be a relationship between factors that make prenatal care and institutional delivery more likely and those that are associated with a move away from the public sector. Identifying the association of socio-economic and socio-demographic characteristics

and patterns of uptake and choice of provider provides important insights into indicators of inequitable health care utilisation.

A limitation of the quantitative analyses is their inability to explain the mechanisms that underlie the patterns of health care utilisation and processes of health care decision-making. The findings do, however, produce further questions, such as why there appears to be a preference for large public hospitals over smaller facilities or how some women from low status groups gain access to private sector providers. They also inspire additional questions related to how women experience inequality and how these relate to their interaction with health services. These questions can be explored using qualitative methods.

Some of these questions are addressed in the following chapter in which I present the findings from the qualitative analyses in the form of a grounded theory of maternity care utilisation.

## **Chapter 8 Qualitative findings and the grounded theory**

The previous chapter examined patterns of maternal health-care utilisation for prenatal and delivery care in the public and private health care sectors in Mumbai's informal settlements. The results suggested a high demand for services but unequal utilisation along a range of socio-demographic and economic characteristics. In this chapter, I describe a grounded theory of manoeuvring, a social practice that offers insight into these patterns.

The first section begins with an overview of the theory and the main argument that the theory follows throughout the chapter. In section 1.2, I outline some of the conditions in which manoeuvring took place, followed by a detailed presentation of the theory in sections 1.3 to 1.6. In these sections, I identify the three major conceptual categories and subcategories that represent the major phases of manoeuvring, illustrated using excerpts from the empirical data. Throughout the chapter, I combine narrative description and the examination of specific cases with analytical reflection to explore the relationship between women's accounts of their care-seeking experiences and aspects of structuration.

### **8.1 Theory overview**

I described the sample selection process in the preceding methods chapter (Chapter 6). Briefly, 75 women who were either pregnant at the time, had delivered in a public or private health facility, or had not received prenatal or delivery care, participated in focus groups and interviews (Appendix I). Information on socioeconomic characteristics and maternity care was missing for 28 women who participated in the first two focus groups because interviewers did not collect it. Of the remaining 47, most were aged between 20 and 29. Thirty-five were Muslim and 13 Hindu. Twenty-one women had lived in Mumbai for at least 10 years and 14 for between one and five years. Ten were receiving prenatal care, 13 had delivered at home, and 19 had delivered in a health facility. Six of these had chosen a private facility, four a public tertiary hospital, 11 a municipal peripheral hospital, and 13 had delivered at home (Appendix J).

The theory of manoeuvring describes a social practice that explains how women, with the support of others in their social network, move between various phases in the maternal health care-seeking process. Utilising health services involves confronting inequitable social, economic, and cultural conditions, and navigating a complex, diverse health care system. The social and economic context of the urban informal settlement provides opportunities and constrains manoeuvring. The interplay between social structure and agency, and its relationship to maternal health care-seeking, is complex. Social and economic structures produce conditions that constrain health practices, such as poverty and social discrimination, normative social expectations (e.g. multiple demands on mothers), unequal relationships of power in the home and in health facilities, and poor perceptions of health care quality. However, these structures can also enable health action through mechanisms such as social networks that provide information and support, and access to resources (income and individual agency) with which to negotiate access to preferred health providers, and to influence their interventions.

The main argument that I develop through the theory is as follows. Manoeuvring represents a form of reflexive monitoring, as described by Giddens in 'The Construction of Society' (Giddens, 1984). It is a social practice in which structures are instantiated and experienced, reflected on, and, in some cases, challenged. I argue that although decisions about maternal health care are influenced by the social structures in which they take place, they are not entirely constrained by them. That is, women and their families are not passive 'recipients' of prevailing structures but reflexively monitor their experiences of and actions with them throughout maternity. These include individual identity and social status, access to social and economic resources, health care decisions and choices, and interaction with health services and providers. Concerns for healthy outcomes, safety, and positive experiences of health care motivate the uptake of maternity care. Continuous reflexive monitoring throughout the care-seeking process influences women's knowledge, perceptions, and understanding of aspects of their health and health care; it produces specific actions and strategies, from the decision to seek health care (e.g. influencing their perceptions of health care options or increasing their knowledge of sources of health care) to the utilisation of services (e.g. taking a loan to facilitate access to the private sector), but also reproduces certain patterns of practice that constrain equitable

utilisation (e.g. restricting care-seeking to public sector facilities or in terms of prevalent norms that equate the consumption of private care with higher socio-economic status).

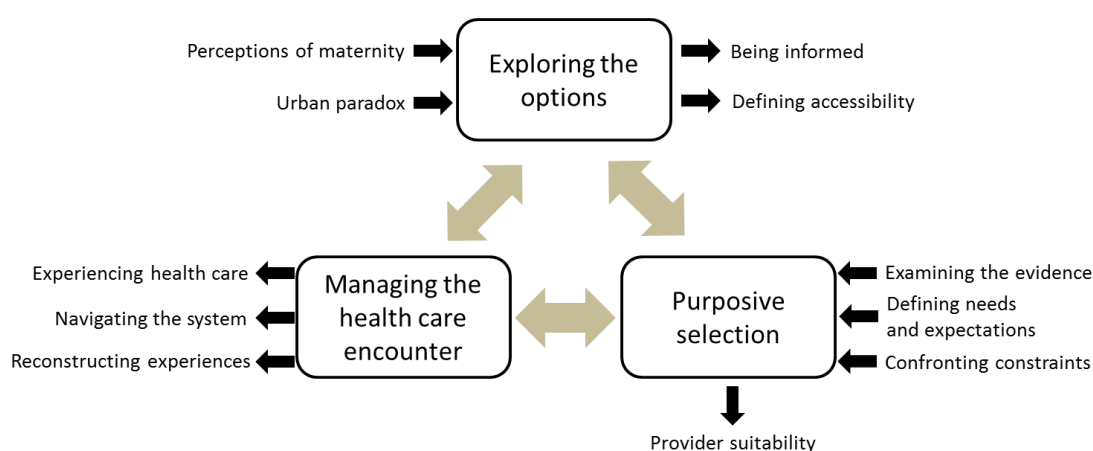
Manoeuvring comprises three broad, interrelated stages throughout the care-seeking process: exploring the options, purposive selection, and managing the health care encounter (Figure 8.1). Exploring the options involves two simultaneous and interrelated activities: seeking information and advice, and defining a 'sphere of accessibility'. In exploring the options, women and their families seek information to improve their knowledge and understand their access to a variety of public and private health care providers. Health care providers are then purposively selected through a complex process in which families define their needs and expectations from health care, and examine the available evidence on a range of resources, including quality and affordability of health services, provider practices and performance, and health infrastructure and equipment. An outcome of this phase is an assessment of provider 'suitability'. Enacting health care-seeking choices involves confronting a variety of social, economic, and psychosocial constraints, and often requires the mobilisation of additional resources where this is possible.

Women and their families make decisions and seek health care in uncertain and changeable conditions. Maternity care usually involves a series of health-seeking 'episodes' over several months, and multiple interactions with health care providers. Women continuously monitor and evaluate their health condition, social and economic situation, and their satisfaction with services, reflecting on their knowledge and ongoing experiences of health care, and using this to adapt their subsequent actions. As a consequence, the decision to seek health care at a particular health facility can change as women's experiences, conditions, and the opportunity to act changes. The result is a variable pattern of health care utilisation and the use of strategic action when engaging with and navigating maternity services. This includes trying and testing services, targeting or avoiding specific providers, registering at more than one health facility, timing visits to avoid long queues, and delegating tasks to accompanying people to reduce the time spent at the facility.



In the following section, I describe the conditions in which manoeuvring took place. Subsection 1.2.1 describes perceptions of risk and uncertainty that participants associated with maternity, explains how they contributed to a perceived need for maternal health services, and shows a general acceptance of a medicalised model of care. Subsection 1.2.3 describes how the urban context of the informal settlement paradoxically creates greater opportunity and increased health care options but, at the same time, contributes to inequities in access.

**Figure 8.1. Theory of manoeuvring**



## 8.2 Conditions in which manoeuvring took place

Manoeuvring took place under two important contextual conditions: perceptions about the risks and uncertainty of pregnancy and childbirth, and an understanding of increased opportunity and choice afforded by the urban environment.

### 8.2.1 Perceptions of risk and uncertainty

Women commonly articulated their anxieties and uncertainties about maternity, the likely experiences of health care, and the potential for poor health outcomes. Pregnant women, older mothers, and mothers-in-law described the perinatal period as a potentially dangerous time, during which both mother and baby were considered susceptible to a range of illnesses and other problems. Primigravid women were understood to be particularly vulnerable and a cause for concern. All women were well aware of the possibility of complication during pregnancy, and childbirth was considered an especially risky event. Several participants recounted personal stories

of maternal loss or described those of relatives and neighbours, which evidently caused considerable distress. During a small group discussion with three young women, one participant unexpectedly announced her own experience of loss:

R1: Once I had a miscarriage...

I: When?

R1: Almost a year ago...

I: Okay.

(The interviewer is at a loss for words. The room is silent. This information makes R2 and R3 look visibly concerned. There is a shift in the atmosphere of the room, it becomes more sombre)

R2: There is a lot of expectation from the first child.

I: At that time where did you go?

R1: Here only, here only in L<sup>1</sup> Nursing Home (private).

I: In L only...

I: In which month did [the miscarriage] take place?

R1: During the fourth.

I: (Inaudible: 22.53)

R1: Yes, I mean (inaudible: 22.56 - 23.02) the child had died ... had no life at all.

(All three participants are visibly upset. R2 is close to tears. The woman who brought in the tea also looks at R1 sadly. The interviewer also feels sad. She offers water to R2. There is silence for a few moments)

I: This was a year ago ...

R1: Yes.

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<sup>1</sup> In order to maintain confidentiality, public and private health facilities have been anonymised throughout this chapter.

R2: When you hear things like these, [my] heart shivers with fear.

(nbcpaprhin0001, focus group discussion with three Muslim women, aged 18-25)

Personal experiences of complication or loss and knowledge of others' problems linked maternity and health care to notions of uncertainty and unpredictability. This added to many women's feelings of distress, anxiety, and fear. As suggested by the excerpt from the focus group discussion, young and primigravid women were particularly apprehensive about their pregnancy, their baby's health and development, and childbirth. Having one's first child is a socially significant event. Much of the young women's apprehension was caused by inexperience, low self-confidence, and fear of complication:

I'm not used to all this, this is my first pregnancy. I would be more at ease if it was my second or third pregnancy, then I would know how things are done and I would get used to it. And I've heard that when it is your first birth there are lots of problems because of her body. The second or third pregnancy is less painful because, by then the road is clear and there is not much tension.

(nbcpapuhin0002, Muslim, 19 years, first pregnancy)

The fear and anxiety that some women felt during their first pregnancy was a factor that motivated them to initiate prenatal care and continue seeking services throughout their pregnancy. As they had little knowledge of maternity and had not previously experienced the physiological effects of pregnancy, they turned to others for support and sought reassurance from health care. In contrast, multiparous women were less anxious than primigravid women about the normal bodily experiences. They drew on their experiences of previous pregnancies to understand their health condition, interpret physiological changes and signs of complication, assess whether action was necessary, and, if so, to inform health-seeking decisions. Lay, experiential knowledge helped establish whether the presence or absence of signs and symptoms was normal or whether it indicated a potential complication. Signs and symptoms that did not fit their knowledge and experience often triggered a decision to seek health care:

During my pregnancy with my youngest child, my health became a bit poor. The whole day water was passing. I did not [understand] because there were no contractions! I had them during my [previous] pregnancies with my daughters, but his time, there were no contractions at all. The water was passing from the morning and I assumed that it must be [normal] just like that ... there was no one to tell me [what it meant], so I did not do anything. By the evening it started passing a lot, like urine ... so we went for a check-up.

(nbddedprmar0001, Hindu, 35 years, five births)

One of the ways of recognising that signs and symptoms were a problem that required action was when they prevented women from carrying out their usual activities. Whenever possible, responses to concerns about physical symptoms were primarily aimed at protecting the fetus and ensuring a safe delivery. Lay knowledge and experiences also informed perceptions about health care decisions and ongoing experiences with health care providers.

Women reflected on their health and the importance of maintaining good health during pregnancy. Maternal health was described as an issue of individual responsibility and some women sought specific information on health-related behaviours from SNEHA community organisers and during qualitative interviews. Questions included what types of food to eat and what to avoid, what position to sleep in to prevent harming the fetus, the potential risks of intercourse when pregnant, and which medicines or supplements to take. Some enquired about what to expect from childbirth, what they should do during labour, and about good hospitals in which to register their pregnancy. Women considered the benefits of seeking health care as a way of averting risk and ensuring a positive health outcome:

The delivery should be safe and successful. A woman [during childbirth] is standing near the mouth of death ... *Allah tallah* (by God's blessings) hopefully everything should be fine.

(Mother-in-law of nbddedprhin0003, Muslim, age unknown, two births)

These concerns about the inherent risks of maternity and the need for a safe pregnancy and childbirth combined with perceptions about the potential benefits of health care to motivate the uptake of maternal health services. Participants described

a range of health and social benefits of receiving institutional prenatal and delivery, including enabling the monitoring of pregnancy and the health of the fetus and helping to protect or restore the health of the pregnant woman and her unborn child. Registering at a health facility also served as a way of obtaining information about health and health care and was necessary for admission to a government facility at the time of delivery –presenting in labour without having registered beforehand resulted in delays or complaints and abuse from health facility staff.

Medicines and supplements supplied by health care providers during prenatal visits were believed to reduce or prevent problems such as weakness and vomiting. Many women reported seeking treatment for these and other common conditions, and that they had “gone and bought all the medicines” and “taken the injection for strength”. This suggests a broad acceptance and internalisation of a biomedical model of health care, especially for common pregnancy-related conditions, and a belief in their effectiveness in reducing symptoms or restoring normal health. Utilising health care performed an important function in helping maintain women’s health, which was central to the functioning of the family.

Some parts of focus group discussions centred on expectations of hospital care. They revealed that consultations with good health care providers and having a facility delivery offered security for the pregnant woman and her baby:

R9: I go for my security.

I: Security ... can you tell us more ... what do you mean by security?

[R9 giggles at the question]

R(?): For the sake of my betterment ...

R11: Something nice should happen to oneself...

R(?): Yes, one should stay well, the children should stay well ...

(nbddedpphin0002, focus group discussion, women with mixed maternal experience)

While most women believed institutional childbirth to be safer than home birth, some said that hospital care was only necessary “when one is in trouble”. Many agreed that

home births posed a potential risk to the mother and baby and required medical intervention. Hospital doctors were best equipped to manage problems during labour because they had the knowledge and equipment to manage the complication. One focus group participant said,

... in the house there could be problems, no? But, over there [at the hospital] they give injections so that it happens normally (natural birth)

(nbdedpphin0002, focus group discussion, women with mixed maternity experience)

Any constraints that families faced regarding health care were less about the availability of services or their ability to access them, and more about how to choose between the numerous alternatives and find the most suitable provider. Despite the high demand for maternity care, uncertainty about quality and outcomes were, as described throughout this chapter, central to decisions about choice. To avoid risk, families took steps whenever possible to access preferred or recommended providers and to bypass dubious or poor quality health care and.

An implicit aspect of seeking institutional maternity care was an acceptance of the norms and expectations of health care providers in terms of women's compliance both inside and outside the ambit of the health facility. This included a commitment to attend appointments, accepting treatments without questioning providers about their use, and tolerating frequent, varying forms mistreatment. There was an evident power imbalance between the low status women and the relatively higher status staff at the health care facilities. Doctors were both revered and feared:

Like the one above [God], if he wants to save he can save, and if he wants he can put any type of injection, and he can neglect also ... A good doctor is one when someone is very serious he gives them good medicines. If there is some problem, even if it's a cold then he should give good medicines ... that is a good doctor.

(nbcpaprhin0001, Muslim, 18 years, primiparous)

Health care providers and other staff possessed, and overtly exercised, their power over patients with little fear of reprisal. Women's bodies seemed to be objectified, perceived as sites of medical intervention. Women seemed to understand this and

communicated it often through complaints of poor communication about treatments or procedures carried out on them without their express permission. As one participant complained, “These people are giving injections and aren’t telling us, then how will we know anything?”. Excluding women made it difficult for them to understand the procedures and from participating in decisions about them. In situations like this, the social hierarchy of the health care encounter went unchallenged and the provider’s dominant position in relation to clients was maintained.

### **8.2.2 Urban opportunity and choice**

Most of the study participants described Mumbai as a place of abundance and opportunity, a place where a wide range of goods, services, and employment could easily be found. As one young woman said, “After coming to Bombay, people who don’t have work find work.” In contrast with the relative hardship and lack of opportunity in the rural areas and smaller towns and cities where some families had previously lived, many associated Mumbai with a sense that you can find “whatever you want, there is nothing lacking here.” The presence of economic opportunity and the wide availability of goods and services meant that people shared a sense of “comfort” and “convenience” compared to living in smaller urban and non-urban areas.

A survey of the study site and surrounding area identified a considerable number of different types and sizes of health facility and diversity of providers, which also gave an impression of an abundance of choice. This was reflected in the range of health facilities women reported visiting for their maternity care. Participants identified a total of 30 health care facilities used for prenatal care or delivery care. Of these, 12 were public sector institutions managed by central or municipal government and 17 were private health facilities ranging from small clinics run by single-handed providers to large specialist hospitals.

An awareness of the opportunities in the city was accompanied by an understanding of inequitable access. Participants recognised the monetisation of urban living and connected opportunities in the city with access to financial resources. One participant

said, “If there is money then all things are there, just that you need to have money.” Limited financial resources often meant that poorer families had to prioritise spending on basic household needs over non-essential goods and services.

### **8.3 Exploring the options**

Although various public or private health facilities were within easy reach of most households in the study area, women did not necessarily choose to have their prenatal or delivery care at their nearest health facility. In fact, except in a few instances, this was rarely the case. Because of the number of alternative facilities and the concerns about safety and quality of care, an initial phase in the decision to seek care involved a process I termed ‘exploring the options’. The two main elements of this process included being informed and defining a sphere of accessibility. The main aim of exploring was to gain a sense of which providers were available and, of these, which ones were within the family’s economic and social reach.

#### **8.3.1 Being informed**

Being informed referred to the process of acquiring knowledge about health facilities and providers, and how to access them. Many participants reported being unsure about health care in general in Mumbai, including “where one should go for delivery and where not to go [...] which hospital is good for us and which is not good”. Other women had experience in one sector or with certain providers, but knew little of others. For example, a Muslim woman from the lowest wealth quintile who, after two home deliveries and two private sector deliveries, was contemplating switching to the public sector for her next delivery had asked her neighbours,

“Where should I register? Where should I go?” I didn’t know about [the facilities] at the municipal hospital.

(nbddedprhin0001, Muslim, 28 years, four births)

Older women with children who had lived in the area for several years were likely to have considerable knowledge of maternity care and know more about the availability and locations of health services. Younger and primigravid women had limited knowledge because they lacked experience of maternity and health care seeking, or



were constrained in their opportunities to move around outside the home. People who were new to Mumbai or from elsewhere in the city, and seasonal migrants, were also unfamiliar with the area. One woman who had lived in her current community for less than a year recalled, “We were new here, we did not know anything about this place, which hospital is good.” Younger, less educated, and migrant women were much less familiar with Mumbai’s health care system, the different types of facilities and services available, and how to navigate them.

Migrants from rural areas were considered uneducated and ignorant compared with more modern urban residents. For example, a SNEHA community organiser, recalling helping a woman who had recently arrived in Mumbai to register her pregnancy, commented that, “she has come from the village for the first time. She doesn’t understand how to talk”. Being ‘uninformed’ made choice difficult and increased the chances of receiving low quality or risky health care. Other conditions including poverty, insecure income, social isolation, and poor access to formalised sources of information made it necessary to find out about suitable providers that were within the family’s means. Therefore, acquiring knowledge was necessary and strongly influenced health-seeking decisions and choice of provider.

In urban Mumbai, health providers offer a range of services and specialities. Facilities have different opening hours and providers often attend on specific days and times and charge different fees. The large number of health care providers spread across the ward and wider Mumbai meant that it was impossible to know about or have direct experience of them all. Participants were well aware of the ambiguities of Mumbai’s health care system and hoped to access choices that helped them avoid poor quality and experiences. Information was a valuable resource for families, not only because improving their knowledge of available health services and facilities increased choice, but also because it helped them identify which providers might be most suitable and which to avoid. In short, being ‘knowledgeable’ improved the ability to make informed decisions.

Access to health facilities and providers was not only understood in terms of physical location and transport, but also in terms of types and quality of services, routine procedures and interactions, and outcomes one could expect at a health facility.

Knowing the likely costs of consultations and treatment helped avoid having to pay beyond the family's means:

Those who don't have money don't have the money. It costs ten Rupees for a form, then to get some medicine for the children from there. To get there it costs one hundred Rupees, and if there are four children ... So she is saying that she is helpless because of this.

(Neighbour of nbddprhin0001, Muslim, 28 years, four births)

Being informed improved the ability to manoeuvre effectively by having knowledge on (1) the availability and location of health facilities, (2) the types of services offered by each provider, (3) the characteristics of each provider and their services (for example, quality, timings, fees and other costs, waiting times), and, therefore, (4) which providers or facilities might be best suited to one's health care needs, expectations, and means of access. Families could feel assured that they had considered a range of options before making a decision. This reduced uncertainty and the risk of having health care with an unfamiliar provider and improved the chances of a more satisfactory experience of the health care system.

Three main ways that participants became informed included drawing on personal knowledge and experience, seeking information and advice, and visiting a prospective health care provider.

#### ***8.3.1.1 Personal knowledge and experience***

Drawing on personal knowledge and experiences provided powerful imagery, both positive and negative, that had an important influence in subsequent health care choices. Using one's own experiences eliminated the uncertainty of relying on others' accounts and recommendations. Experiences could be recent or in the past, such as a previous delivery.

Women reflected on positive previous experiences as evidence of provider competence and quality of service, which reassured them about safety and the level of care they could expect in future. This often motivated them to return to the same provider. In contrast, negative experiences discouraged repeat consultation and often

triggered a search for an alternative provider, requiring recourse to the social network for information. The value of personal previous experiences was enough for a positive experience to carry more weight when making subsequent decisions than other factors such as proximity or more convenient timings.

#### ***8.3.1.2 Seeking information and advice***

Women were members of formal and informal social networks of various sizes and densities. In addition to, or in the absence of, personal experience, social networks provided a straightforward and valuable source of relevant and reliable information, particularly in terms of access to members' personal experiences of health care-seeking:

I asked my husband and other people. So they told me that M (municipal hospital) is good. Now, if someone says that it is good, then we will also feel it as a good hospital only, no?

(nbddedpuhin0002, Hindu, 28 years, four births)

Asking others in the network about their experiences and outcomes of health care was relatively easy. Most commonly, women turned to members of their proximate social network, mainly immediate family, other relatives, and trusted friends and neighbours. Experienced women such as mothers-in-law or other relatives and acquaintances with children were valuable sources of local knowledge. In the densely populated communities of the informal settlements in the area, neighbours often knew each other's affairs. Chatting and gossiping in the alleyways outside their houses was an everyday routine for many women, some of whom spent much of the day at home. Some younger women felt embarrassed about discussing reproductive issues with older women. For them, access to information was a more passive activity, often involving overhearing other women discussing their experiences.

Social networks served as conduits for the flow of information and advice among neighbours in a way that "you come to know from each other". Informal conversations provided a relatively abundant and straightforward source of information on women's health and maternal health care-seeking:

There are all women (neighbours) around us. If someone is sitting in the lane, then they will talk about this only no? ... (giggles) ... One will ask, “*Bhabhi* [older sister-in-law], where did you go [for your delivery]? What happened there? The whole day the person is at home, when you pass someone or other [they] will obviously say that “Yes, it was a normal delivery” or that “We had stitches, the doctor did this, or something like this happened...”

(nbdeachin0001, Muslim, 23 years, one birth)

The excerpt indicates that social networks enabled access to various types of information, not only about the availability and location of providers, but also about other women’s experiences of health care, medical services and interventions, as well as their outcomes. It suggests that some women sought to construct a broad and extensive knowledge of health care to help them make choices that suited their requirements. Acquiring this information helped identify, for example, which providers offered affordable services and which were reputable. As one participant said, “I heard that she is a good doctor, so I registered my name there.” Having more, relevant knowledge and information increased some women’s capacity to exercise influence health decision-making, enabling better judgement about available choices:

R: [My husband said], “At the end of the day, it’s your choice. We shall go to whichever hospital you feel gives better treatment and you have information about it.” We will go only to that hospital about which we have information, no?

I: What information are you referring to?

R: Like, having information about the hospital, which hospitals have good facilities for deliveries, where to go ...

(nbddedpuhin0001, Muslim, 26 years, three births)

Speaking to experienced others helped obtain locally-relevant information tailored to their social and financial circumstances. For example, women could seek a recommendation for an affordable provider:

I asked two-four (several) women, “Where should I go? I don’t have much money. What should I do?” Then she told me, she said that go here [to this nearby hospital], the thing is that less [money] will be required here.

(nbdedprhin0001, Muslim, 28 years, four births)

Members of the proximate social network with shared socio-economic and cultural backgrounds, who were likely to have sought health care under similar types of conditions as the women seeking information from them, were ‘ideal’ sources. Crucially, they had experience of the manoeuvring process themselves. Sourcing information from these networks had two possible consequences for patterns of care-seeking of other members. First, in smaller social networks or those in which most members sought maternity care with a limited number of providers (e.g. only public sector health facilities), the range of options available to other members would also be limited, therefore reproducing similar patterns of health care utilisation limited to a small number of providers known within the network. Alternatively, larger networks or those with diverse membership might expand opportunities for other members; for example, by giving information about accessible private sector providers and encouraging the production of new, diversified patterns of care-seeking.

#### ***8.3.1.3 Visiting a prospective health provider***

A few women recalled visiting a specific health facility that they were considering for their maternity care. The degree of personal experience and familiarity that women had with health providers influenced the extent to which they explored potential sources of care. Most commonly, they visited a prospective provider after they had received information from their social network but had not directly experienced it. Visiting the health facility served at least two purposes: it allowed women who were considering using the service to verify information provided by the network, and it gave them an opportunity to seek specific information about the place and its services, such as consultation fees:

I inquired at a private [clinic] as to how much they charge for a normal delivery. They said it would cost me 15,000 Rupees! ... My neighbour delivered at a private one; there she had to pay 13,000 Rupees just for a normal delivery, excluding the expense of medicines, which had to be bought separately. So they charge you 15,000 Rupees generally and 20,000 Rupees if they conduct an operation.

(nbcpapuhin0002, Muslim, 19 years, first pregnancy)

The woman in this interview was pregnant with her first child. She had registered and had been attending a municipal peripheral hospital for prenatal care, where she planned to deliver. This hospital had been recommended by women in her neighbourhood. Although she reported being generally satisfied with her experiences of the service, her neighbour told her that she had delivered privately, which motivated her to find out the potential costs of a private delivery herself.

It was not always necessary to visit a health facility to form an opinion of it. One participant said, “In the market, people say that M [maternity hospital] is good.” Another had heard that the staff at the local municipal hospital hit and shouted at patients: “[people] say they yell at you and slap you on your thighs”. The reliability of the information and its source was less important than the imagery it conjured up. This points to the idea that women were seeking to build up a picture of the health care ‘terrain’, but that this picture was bounded by the limits of personal knowledge and experience, the structure of the social network, and the information provided through it. The implication is that, beyond concrete information or ‘facts’ about health care, perceptions and imagery play an important role in the process of decision-making and provider choice.

### **8.3.2 Defining a sphere of accessibility**

An initial phase in the health-seeking process involved understanding the setting in which health decisions were to be made and gaining a sense of accessibility to different types of health facility and provider. This involved women and their families defining the scope of their health-seeking opportunities in relation to a socially constructed understanding of self and socio-economic position. Building on their own knowledge of health care facilities and providers, information and advice from the social network, and visiting health facilities during pregnancy, women considered their social and financial position. This was mainly discussed in terms of a household’s financial situation and perceptions of social status.

I conceptualised this phase as defining a sphere of accessibility, which involved two main elements: assessing household financial capacity and internalising one’s social status.

### **8.3.2.1 *Assessing financial capacity***

Health-seeking decisions involved a financial component for a number of reasons. Maternity care involves repeated visits through pregnancy to delivery, incurring direct and indirect costs such as transport, provider fees, supplements and medicines, and potential referral from one facility to another. Moreover, costs of health care varied between providers and services. All of these factors implied ongoing and potentially spiralling costs that threatened household stability and contributed to financial uncertainty.

Residents of informal settlements were aware of the precariousness of their financial situation, but also the consumer opportunities and costs of services in urban Mumbai. Women talked about work and income, having to balance buying food and managing other household expenditures with spending on health care.

We live in a rented room, have to pay 1500 Rupees and the deposit is 15,000 Rupees, 20,000 (inaudible: 7.08). These are all the expenses for this week, so 2000 Rupees is not sufficient. But still I have to manage everything somehow, depending on our capacity.

(nbcpapuhin0002, Muslim, 19 years, first pregnancy)

Because of the potentially serious consequences of health care on household stability, it was necessary to understand one's financial situation before seeking care. As one woman summarised it, "you have to see the [household] financial condition, no?" Families continuously assessed their financial capacity to access different types of health care in relation to other household expenses. One participant's neighbour explained the difficulties of managing health care costs on a limited income:

The thing is that whatever her husband gives her for household expenses, with that amount she has to manage the [household] expenses and whatever money is needed for the medicines, she is saying that. And the husband doesn't earn much, so where will the money come from? [One] Can spend only according to income, no? You can only stay in Bombay (Mumbai) when you have a high salary of 20-25 thousand [Rupees]. What is an income of 10 thousand, 12 thousand? So, that much is the income. If he gets one thousand per week then how much is that? In that money, children ... they fall sick 3-4 times.

(Neighbour of nbddprhin0001, Muslim, 28 years, four births)

Despite the constrained of limited income and difficulty meeting household expenses, many women from across the socio-economic spectrum aspired to access private care because they perceived the services and treatment from staff to be of higher quality:

If I was financially strong, then definitely I would register my name in a private hospital! I would register my name in private because then there would be more comfort, there are people to take care [of you].

(nbcpapuhin0002, Muslim, 19 years, first pregnancy)

Most women from poorer households understood how their poor financial status limited their opportunities for maternity care to government or municipal health facilities. As a result of the precariousness of some households' financial situation and the implications of potentially catastrophic health care costs, health care decisions were often short-term, made on the basis of proximate health needs and the potential costs required for the next care-seeking episode.

#### **8.3.2.2 *Internalising status***

A second dimension of defining a sphere of accessibility involved an internal process connecting a socially constructed understanding of status or identity with a perceived opportunity to use health services and access specific providers. A common term used to describe this was *aukaad* (or *auqat*), a Hindi word indicating an individual's social position or standing (Natrajan, 2012, Varma, 2004). Within a framework of caste, *aukaad* is a psychosocial construction that differentiates people culturally and is often used in a pejorative, limiting way. According to Natrajan (2012: xvii), *aukaad* expresses a form of casteism that keeps 'individuals in their (socio-economic) place'. In Indian society, everyone requires *aukaad* to know their place, and it informs normative social behaviours. At the same time, individuals are expected to confine their self-perceptions and social behaviour to their status and not to exceed it (Varma, 2004). The sense here is that people should accept their lot and not "get above themselves". This was expressed by a 28 year-old Hindu woman with no education in the medium wealth quintile when she said, "I analyse my situation and then I behave accordingly."



Low social status was related to financial hardship and produced a feeling of “helplessness”. *Majboori* (helplessness) signified a lack of control over their lives, a strong characteristic of poverty. A consequence of perceived low social status was coming to terms with the inability to access a good standard of care. Women who described themselves in terms of lower class or status perceived their opportunities for health care and choice of provider as more restricted than those of others. The sense that poor women were ‘dispossessed’ of money and status was internalised and understood to mean that “... poor people, because of their troubles, they have to go to government [health facilities]; they lacked the opportunity to access private sector health care: “We don’t have the status to pay for private. Out of helplessness one goes more to government only.” They also described themselves as being socially subordinated to more powerful or higher status health facility staff. One of the women from a focus group discussion expressed a hope that health care staff would “talk to us properly” and “consider us humans like them”.

The implication of the notion that action is partly determined by an individual’s perception of their position relative to others is that this perception is highly constraining. If true, health-behaviour would conform to socially patterned norms, which might hold regardless of where on the socio-economic spectrum the individual perceived him or herself. In fact, generally, those who used the term to describe themselves were from poorer economic groups, younger, less educated, or recent migrants to Mumbai. These women perceived themselves as socially disadvantaged and distinguished themselves from more prosperous women by comparing “those who have status and those who don’t”. When women perceived their sphere of accessibility to be restricted, they sometimes talked about coming to terms with their situation (“I’ve opened my heart”) and trying to see the positive side: “However [bad] it is, it’s still not that bad”. In other words, accepting the inability to overcome financial and social constraints and how this limited choice resulted in a ‘lowering of expectations’. Some women found it difficult, or were unable, to explain in detail how and why they made choices about their healthcare provider. For them, ‘choice’ was obvious: because it was so constrained, there was no choice. In this way, they articulated their access to health care in terms of how their relative social and economic situation defined their degree of opportunity, as well as behavioural norms associated with their status.

If the concept of *aukaad* is as highly constraining as the definition implies, the health-seeking actions of women who perceived themselves as low status would be limited to inexpensive private providers or the public sector, of which they have low expectations. As a consequence, the structures that produce inequitable access would be perpetuated. The Hindu woman above might have been referring only to the conditions of her most recent delivery, in which case it does not reveal how her perception of herself influenced her previous choice of private sector deliveries. The concept also suggests a certain permanence and excludes the possibility of change over time; for example, if one's conditions improved or one acquired the capacity to challenge it.

In summary, perceptions about the sphere of accessibility emerged as the result of a convergence between one's social status, a sense of responsibility to the family, household financial capacity and perceptions of health care costs. A combination of material and non-material elements was responsible for women's perceptions of their opportunities for health care. However, that some women from lower status groups sought private sector care (as shown in the preceding quantitative chapter describing patterns of care-seeking), suggests the possibility that, in some circumstances, the constraining structure of perceived social position might be challenged. In subsequent sections of this chapter, I explore in more detail the ways in which some women did this and their motivations for doing so.

#### **8.4 Purposive selection**

Purposive selection refers to the process of identifying and choosing a specific source of maternity care from the range of alternatives, including a traditional birth attendant (*Dai*) for home births, public sector facility, or private provider. It describes how women and their families applied their knowledge and experience of health care, and the information gathered through their social networks, with perceptions about the need for health care to identify potentially suitable providers. This process involved three interrelated phases: examining evidence relating to individual facilities and practitioners, defining health care needs and expectations, and confronting the conditions that constrained health care-seeking.

#### 8.4.1 Examining the evidence

Examining the evidence on available health care providers meant reflecting on one's own knowledge and experiences, those collected through interactions with members of the social network, and any other sources of information accessed during the information-seeking phase. A need to examine the evidence reflected the uncertainty that many women felt about health care, and the potential for a poor outcome and experiences. Examining the evidence involved women assessing their knowledge and experience of health facilities and providers, their source (e.g. from personal experience or information received from a neighbour), and making judgements about them. All of these factors combined to influence health-seeking choices:

I used to go to that doctor [from CA nursing home]. That doctor is proper, she is really good, she explains everything properly, gives medicines and stuff properly too ... because of all these things I went there to that doctor.”

(nbddprmar0001, Hindu, 35 years, five births)

Faith or trust in providers encouraged women to continue receiving their health care at the same facility. Evidence of satisfactory experiences and successful outcomes, such as having a normal delivery, encouraged perceptions of trust and a tendency to continue care with the same provider:

I: You know ... you said that the in-laws have their trust in this particular hospital...

R3: Yes.

I: So, what I am asking you is, can you tell us why your in-laws trust the hospital ... (to R2 and R3). Your in-laws trust J, yours (to R1) trust L ... so, why do they trust these hospitals so much?

R1: Because their daughter's son was also born there, they trust that if we register our daughter-in-law's name here, then they will give proper medicines ... they look after [in their experience during their daughter's time] well, that is why they trust.

(nbcprh0001, focus group participant, Muslim, 25 years, one birth)

Faith and trust were not automatically assigned to health care providers by virtue of their medical status, and often had to be earned or ‘proven’ to clients. One of the young women from the focus group discussion above went on to explain that, while her in-laws trusted that the provider would be suitable for her, this would be assessed at the time that the service was utilised:

R2: Right now you are telling us that we have trust ... we feel like that, we feel that they will take good care. Now this is our first child, we will come to know if they look after us well or not. If they don't look after the first child well, then we [will look for something else] the second time.

(nbcpaprhin0001, focus group participant, Muslim, 25 years, one birth)

As the excerpt indicates, women examined evidence on certain qualities of providers and their services when making health care choices, but also reassessed those qualities at the time of receiving them. Assessments of provider suitability were therefore an ongoing process. This was particularly relevant for women with little or no experience of health care, and those who intended to switch from a familiar sector or provider to an unfamiliar alternative. When women came to know about another person's positive experience or outcome with a particular health provider, they often registered their own pregnancy at the same health facility: “I also knew that the hospital is good. My brother's wife delivered a baby boy at this hospital and everything went well, therefore I also registered my name there.” This tendency often continued in the family:

[I visited] This [M] only. My mother also delivered there. And my mother said that everything happens correctly. My mother-in-law's also happened there, so she said that it's near and it's good, they do it correctly, so I used to go there.

(nbddedpumar0002, Hindu, 28 years, four births)

Women were drawn to popular providers on the premise that if lots of people used them they must be good: “Lots of other women have had their deliveries at this hospital. People said it is a decent hospital, so I decided to come here.” When women felt that providers had a reputation for good care or successful, normal deliveries, they began to trust them:

So that doctor is very famous, I mean people who stay really far away come to see him. That's why everyone has more [trust or faith] in that doctor. Because of this my brother's son was born there, and when his wife got pregnant for the second time we got her delivery done at the same place

(nbddedprmar0003, Hindu, 30 years, one birth)

Having contacts at a health facility also brought several potential advantages to choosing one facility over another. One woman said, "If there is some problem then they can be with us. They will be with us during tough times." The field note annotation below summarises the case of a woman who had registered in the public sector because she was poor, but chose to visit a private clinic instead because she perceived her condition to be too serious to be managed at a municipal maternity home:

Although she says she prefers municipal hospitals (she's had three previous deliveries in D) but delivered in a private clinic, one could ask why she didn't initially choose this CA private hospital for her delivery rather than registering at M municipal maternity home? She reveals that they chose the public sector because they are poor but that she ended up coming here because she perceived a complication and knew which facility was appropriate to manage it.

In the excerpt above, the woman's assessment of her complicated health condition caused her to re-evaluate her original choice of provider, even though it was constrained by her poor financial situation. It was her re-examination of her knowledge of different health care facilities and their services that led her to select an alternative provider she knew was competent to treat her condition.

Examining the evidence resulted in the formation of perceptions about public and private sector providers and an understanding of which facilities and providers would most likely to offer safer and more satisfactory experiences.

#### ***8.4.1.1 Forming perceptions of public and private providers***

Women and their families formed perceptions of providers in the public and private sectors by examining and reflecting on their knowledge and experiences of health care. Interview narratives were replete with contrasting accounts and opinions that

pitted the public and private health sectors against each other. There was general consensus that public sector institutions provided an inferior standard of care compared to the private sector and that it was usually poorer families who used public sector services. Women described public sector hospitals as understaffed and overcrowded. Larger public hospitals were popular and “so many people come”, so that public services were more appropriate for “those who have more time” and who “have people at home to go with them”. They felt that the municipal doctors provided good clinical care but were difficult to access, and that the nurses and auxiliary staff were rude and inattentive. Some believed that medicines in government hospitals were ineffective in providing relief.

Overall, families preferred the private sector because the quality of services and interaction with providers were superior to those in the public sector. Women reported that, “the facilities are good, they give proper medicines and care” and, “There is peace of mind, no? Everything happens in private with peace of mind.” Differences were commonly explained as the financial incentive to deliver quality services: since public services were free or comparatively inexpensive, the quality of experience was expected to be lower; conversely, because private sector providers charged relatively high fees, they were obliged to provide a superior service. The general belief was that if you paid for health care you expected a more satisfactory experience because “we are giving our money to be taken care of”. The implication was that standards of care and quality of interaction were understood as a commodity that had to be purchased, and that, by paying a considerable fee the standard of care and quality of interaction with staff was much higher. The perception was that women who paid for health care were more ‘likely to receive quality care than those who relied on free government services. A commoditised understanding of health care meant a perception of the quality of services and provider care commensurate with their fees: “they take better care because they charge you more”. On the other hand, public hospitals and some less expensive private providers were more affordable, but offered a lower standard of care:

R: The difference [is] they take a little bit [more] care in private because they take money. That is their work. But in BMC (municipal health facilities) ... there is a carelessness of sorts.

I: Regarding what?

R: If a woman goes for a delivery then she will keep screaming inside...the nurses sit outside and there is no way that the doctors come. Normally (her word) the sister only does the delivery.

(nbdedprmar0001, Hindu, 35 years, five births)

However, some participants doubted the motives and practices of some providers, such as profit-motivated private practitioners who “only become doctors to earn money”. Many were concerned about – or recalled – being mistreated by hospital staff. Others feared hospitals and having to undergo medical procedures:

[In hospitals] They cut with blade (cesarean section). Then they say that they stitch it, so that’s why I’m very scared of all these things.

(nbdehbrhin0002, Muslim, 30 years, four home births)

#### **8.4.2 Defining health care needs and expectations**

Practical and internalised constraining structural conditions, such as those described above, meant that provider selection was not necessarily driven by the intent to access the highest standard of care possible. Rather, by understanding the conditions and opportunities, providers could be selected according to their suitability to circumstances and needs. This meant that families had to define their needs and expectations to identify suitable providers. If conditions changed, or as women evaluated their experiences of health care, their definitions of needs and expectations could be modified. Defining health care needs and expectations were developed around various factors, which influenced choice of health care provider. These included the following:

##### **8.4.2.1 *Positive health outcomes***

Many women expressed a concern for finding a provider who would be considerate of their health care needs and help ensure a positive health outcome. This was a major reason for seeking institutional health care and for choosing a specific provider over others. Even women with low expectations of health care agreed that, “the only thing a person expects is for [the delivery] to go smoothly.” This meant having a

safe, uncomplicated or “successful” delivery. One primigravid woman said, “I’m just hoping that the delivery is successful and the child is born healthy.” Delivering in a health facility reassured families that the birth would be conducted safely and the mother and newborn would be healthy.

#### **8.4.2.2 *Appropriateness of care***

Women monitored their conditions, health, and appropriate sources of care throughout their pregnancy. Families wanted to access facilities that could provide them with an appropriate type and level of care. As long as they felt satisfied with the service they had received, when pregnancies were progressing normally, the most common tendency was to continue using the same provider. In the event of illness or complication, health care needs changed and provider suitability was reassessed. This could involve switching from the original facility or to an alternative, more competent or trusted provider. An example of this was described in the field note excerpt above.

#### **8.4.2.3 *Convenience***

Women often referred to “convenience” as a reason for choosing a particular provider or as a health care requirement. Convenience had multiple meanings, including comprehensiveness of services, affordability, efficiency of care, and distance and time required to access a facility.

##### ***Comprehensiveness***

Hospitals with comprehensive, integrated services, modern equipment and technology, expertise and specialised care were attractive and convenient because, if complications arose during maternity care, they could be treated without the need for referral.

According to me, D (municipal general hospital) is proper because whatever happens they treat you there and then, and there is no need for them to send you to another hospital. The people at M (municipal maternity hospital) have to sometimes send [women] outside [refer to other hospitals] ... to special doctors.

(nbddedprmar0001, Hindu, 35 years, five births)



Some women preferred facilities with integrated services because it gave a sense of reassurance that health personnel could “investigate everything properly”. This made them safer and more convenient since there were services for any health condition or diagnostic test. Private sector care was also convenient in the sense that services were usually perceived to be better quality and more efficient:

R5: There is convenience for everything in [the] private [sector]. [Patients] are looked after well in private.

R2: It takes money but [everything] happens quickly

(nbddedpphin0002, participant attributes unknown)

### *Affordability*

As already outlined in the section defining a sphere of accessibility, the economic aspect of accessing health a range of services was a primary factor in health care decisions and choice of provider. Dimensions of affordability included: (1) matching the family’s financial capacity with knowledge – or perception of – direct and indirect costs of health care, (2) mediating aspirations and preferences for one sector or provider over others, and (3) assessing whether the potential costs would produce a benefit in terms of better outcomes. Affordable health care was “convenient”, although it was usually understood as a constraining concept and related to lower standards of care:

R5: A person goes to government for their convenience.

I: What do you mean by convenience?

R5: That less money will be required over there ... They [public sector providers] don't give much information, even if you shout or you die or whatever – there is not much information in government as much they give in private [facilities]. Agreed, they take money but they give more information over there. Not in government ...

(nbddedpphin0002, participant attributes unknown)

Participants expressed a strong preference for private care. However, because of the much higher costs compared with the public sector, this was often mitigated by concerns relating to affordability. Many women said, “If you deliver in [a] private

[hospital] then the expense will be higher. Go to BMC (municipal facilities).” In the following excerpt from a focus group discussion, women were asked about their reasons for giving birth in a government hospital:

I: Will you share the reason for going [to a government hospital]?

R8: We don't have the status to pay for private. Out of helplessness one goes more to the government [health facility].

R2: When one delivers in private, it takes fifty to sixty thousand [Rupees] for an operation ...

R8: Yes.

R2: And at the government [facility], the work is done for four-five thousand; rent (bed charge) and everything after running around (looks at the other women), yes or no? Because of that ...

R8: Because of this only [I] go to government.

(nbddedpphin0002, participant attributes unknown)

The excerpt illustrates the pervasiveness of the financial aspects of health care-seeking in urban India and the constraining effect of poor social and economic conditions on women's perceived and real access to health care. Even some relatively wealthy women considered the higher costs of services in the private sector – especially for routine care – excessive or out of reach. One woman from the highest wealth quintile who had given birth to all four of her children in a local public maternity home said:

Who will pay such high costs? Our condition should also be like that no. Now, you see even if any small thing arises no, then directly they say ten thousand or five thousand, then how would we give so much [amount of money]?

(nbddedpumar0002, Hindu, 28 years, four births)

Although women aspired to access the private sector for maternity care, the financial cost appeared to be a potential barrier even to wealthier families. On the other hand, this woman's reflections give the sense of a devaluing of maternity, and women and

children. A cost of five or ten thousand Rupees is not out of the reach of wealthier families in informal settlements. Given the emphasis on safety and positive health outcomes, it does not seem a high price to pay.

### *Efficiency and efficacy*

Affordable care was not just assessed on the basis of direct and indirect costs, but also on aspects of efficiency and efficacy of services. These services were typically associated with private sector providers who were more likely to prescribe higher quality medicines and more prompt attention. Although the initial costs of accessing an efficient and effective service could be high, especially for poor families, the perception was that less time in the facility and quicker recovery time would lead to savings in the long run. In one interview, the participant explained why, despite having a limited household income, she had taken her infant to a private clinic:

So that the children become fine soon, the child has so many troubles that you have to take the child and if you go to government then the children recover only when you go there for three or four days. If you go here [in private] they recover in one day. So when you see these problems of the children then you have to go [to private].

(nbddedprhin0001, Muslim, 28 years, four births)

These types of decisions involved evaluating health problems and the possibilities for health care with the condition and needs of the household. According to the child's mother, when children fall sick, their health needs take priority over others: "when the children are in trouble you have to go, even if there is no money to eat, you have to look after the children."

### *Proximity and timeliness*

Women complained of the time required to seek prenatal care at government health facilities:

There is huge crowd there. [We] sit in the queue for the check-up. If you go in the morning at around 8 am then you generally come back at 2 or 3 pm. You have to be in the queue from the morning for the check-up.

(nbddedpuhin0004, Hindu, 22 years, four births)

Distance and time were important factors in decisions about maternity care. In this respect, the public sector was consistently criticised for its time-consuming queues and procedures. Women who had to manage multiple responsibilities and had little support at home had limited opportunity to spend time in a health facility for routine check-ups. One woman said:

I don't have time, everybody knows, there is no time. My two children go to school. My husband doesn't stay; he goes out for his work. Every day I'm alone, I don't have so much opportunity that I can go to municipality, get a number in the queue ... so the whole day goes in it.

(nbddedpphin0001, focus group discussion, women with mixed maternal experience)

Although proximity was not usually the principal criterion for selecting a health care provider, in some circumstances women often found it preferable or necessary to use a nearby health facility. For example, travelling a long distance was an inconvenience to be avoided unless necessary. The wide distribution of health facilities across Mumbai facilitated access to a range of providers and offered the possibility of choosing one that was convenient:

“... there are so many doctors, we will go where it is comfortable for us to go ... for some, it is closer so they go there.”

(nbddedpuhin0002, Hindu, 28 years, four births)

Another reason for not travelling far was the need or tendency to be accompanied. Being outside the home for a long time was inconvenient for people who needed to accompany the pregnant woman. It was sometimes difficult to find someone: “there is too much of traveling involved and who would have accompanied me there?” Others might lose a day's work and salary:

If my husband came along every time I had to go for my check-ups then it would cause him huge loss at his work. His daily wages will be reduced.

(nbddedpuhin0001, Muslim, 26 years, three births)

For some women, the only choice was to go to nearby health facilities. Women with limited opportunities to move around outside the home or who had no one to accompany them could still access health care if it was nearby: “I registered my name there for my convenience. If nobody is there with me I can still go.” This was especially important for women with low social support or a high burden of responsibility in the home. One woman who lived in a nuclear family and whose only support was her husband said:

If the hospital is nearby you can go and come easily ... my husband can look after me, he can also look after the children. He can look after me, but if they [had] sent me to hospital F, then my husband would have spent all day traveling to and from the hospital. Not only would he lose an entire day's work but even my children would be neglected. There would have been no one to look after me regularly there at F.

(nbddedprmar0001, Hindu, 35 years, five births)

Seeking care at a nearby facility helped because it enabled women to return home quickly, avoiding a detrimental effect on the household. When asked why she had chosen a nearby provider for her maternity care, one participant said, “We can go quickly and then come back in time and do our household chores”. Another said:

[M] is good because it is near. I can't deal with distance, I have two small children ... My children were really young and small ... I thought I shouldn't go that far. Because of that I decided that I will go to the one nearby.

(nbddedpumar0003, Hindu, 30 years, three births)

Since there were relatively fewer public sector health facilities and they were more sparsely distributed, poorer families who could not afford conveniently located private care had less choice. They might have to travel further to reach affordable public health services. This meant extra transport costs and less time for work at home or income-earning activities:

The government hospital was also there, but it is far ... Managing all the household chores, and then looking after the children, and then going there was not possible. I need to see to the household chores also, so it was not possible to go to the hospital

far away. It also gets late. Now, here [M municipal maternity hospital] it is near and [we] could reach there easily. (nbddedpumar0002, Hindu, 28 years, four births)

Women who were compelled to use public health services that were further away had to make adjustments to avoid interrupting their household responsibilities. For example, one woman reported having to get up very early in the morning on the days of her prenatal check-ups at a government hospital so that she could complete her household chores before she left home.

When nearby facilities lacked services or equipment, or in the event of medical need, some women took steps to travel further in order to access care at a superior health facility. One travelled 12 hours by train in order to deliver with a well-known private doctor with a reputation for successful deliveries. Some women considered the possible consequence of labour and pain for the practicalities of travel and reaching a health facility on time. Choosing to register in a nearby facility was one way of ensuring an institutional delivery:

It should be nearby only. If it is far from home then there is traffic and it is difficult to get there. If it happens that suddenly the delivery happens then it would not be possible to move from there.

(nbddedpumar0002, Hindu, 28 years, four births)

In cases where the preferred hospital was far away, one strategy was to simultaneously register in another facility (i.e. in two places) nearer by. In this way, if there was insufficient time to reach the preferred facility at the time of delivery the family could attend the nearest one:

Yes, that's why, whichever could be reached quicker, and if this one is closer, then [I'll go] there. And what would happen if there would have been no one nearby? And during the first time we did not even have a phone at our home. It was just me and my mother-in-law at home. Who would have taken [me to the hospital]? There were no males.

(nbddedpumar0001, Hindu, 25 years, three births)

#### **8.4.2.4 Positive interaction with health facility staff**

Women wanted to avoid negative encounters with medical and non-medical staff, particularly in public sector hospitals.

What happens at BMC (Municipal Corporation) is that the [medical] treatment there is proper. But sometimes when a woman goes there for a delivery, if she happens to scream [in pain] or if she has some discomfort, then she is ignored. Those *ayahs* (cleaners) say such ... bad things. I can't even bear to hear those things with my ears ... Half the women go private because of this.

(nbdedprmar0001, Hindu, 25 years, three births)

Women often expected, either from personal experience or from speaking with others, that staff might be inattentive, discourteous, and sometimes abusive towards women, especially those from lower status groups or 'deviant' individuals, such as those who had registered late or exceeded the two-child norm. Government health facilities are directed to charge a fee for deliveries where the birth order is higher than two. Because of this, some pregnant women with more than two children tried to avoid health facility staff finding out. In the following excerpt from a focus group discussion, a SNEHA community organiser recounted accompanying a woman to a municipal hospital:

*Bhabhi* (sister) please don't tell them that it is my third child ... Tell them it is my second. The women around me in our neighbourhood have told me that they will berate me and shout at me if I tell them that this is my third child.

After persuading the woman that it would be better to tell the staff the truth:

And then the woman [staff] tells the patient, "You are reproducing a third child? Weren't you satisfied with two children? Why are you removing [rude way of saying delivering] a third child? You have come to this hospital for delivering? Where were you from so many days? ... Do you like sleeping with your man?"

(nbcohin0001, focus group discussion, SNEHA community organisers)

Most women felt that health care providers, regardless of sector or level of care, had a responsibility to act respectfully and professionally towards all service users,

whatever their background or health circumstances. They believed that health providers “should take good care, should pay attention, and should do a good delivery.” Even those who accepted that the quality of services in any public sector facility might be lower said that health care staff had to act in a supportive and empathetic manner and should focus their efforts on treating and caring rather than abusing:

The main expectation is that during the time of delivery, [staff] should pay attention ... the woman is suffering, her problems aren't going to go away by you saying things [shouting] at her. Rather, give her some medicines, injections, or say something to her so that her delivery will be quick. The patients, the women, say that when someone screams at you the delivery doesn't happen quickly. So you [hospital staff] should explain everything rather than shouting at them.

(nbddedprmar0001, Hindu, 25 years, three births)

Families went through various cycles of exploring and purposive selection throughout maternity. The first stage commenced when initially considering care, such as in planning for the first prenatal consultation, but was re-evaluated and repeated as women engaged with and experienced health care. This continuous reflexive monitoring of the conditions and opportunities influenced the demand for new information and understanding, and was a persistent feature of manoeuvring throughout repeated cycles of health care-seeking. For example, if private health care became unaffordable or if a family was dissatisfied with care, they often returned to exploring alternative options and purposively selecting another. The identification of new or potentially suitable health care providers gave families some reassurance by reducing the uncertainty of using an unfamiliar or unsuitable source of care.

### **8.4.3 Confronting constraints**

Patterns of health care use and choice of provider were influenced by a variety of constraining conditions, most evident during initial decisions to seek care, when families were preparing for a facility-based delivery, and when responding to symptoms of complication because of the material and social resources required to carry them out. Confronting constraints meant evaluating one's circumstances and the potential to influence them so that decisions and preferences could be fulfilled.



The ability to confront these constraints had a direct bearing on decisions about whether, when, and how to utilise maternity services.

As an illustration, the following section considers the interrelationship between family structure, cultural and social role expectations, and access to social support. It is intended to illustrate how structural constraints are experienced and acted upon differently, as well as how women interpreted and communicated them.

Women's participation in health-seeking decisions varied and was affected by their age, the location of care, the structure and dynamics of the family, and their access to resources such as money, time, and social support. After marriage, most women went to live with their husbands in their family home. Younger primigravid women had low autonomy compared with older, multiparous women. In line with tradition, most young women returned to their natal families for the birth of their first child and had minimal participation. Besides following a strong cultural tradition, some women said they returned home because there was no-one to support them in Mumbai. There were also social and financial benefits to returning to the natal home. Firstly, women said they felt safe and more at ease and received better physical and emotional support from their family. Secondly, some preferred to seek maternity care at facilities and with providers with whom they were more familiar. Thirdly, the expenses relating to childbirth and hospital care were purportedly relatively lower in the village than in Mumbai if provider fees, transport, meals, and other considerations were taken into account. Mothers and other relatives usually took responsibility for all of the decisions and arrangements relating to the daughter's first birth. Given its long history and cultural significance, primigravid women did not seem to challenge the practice.

Other women lived with their husband and his family. In the social hierarchy of the extended family, older women wielded relatively greater power than younger women. A mother-in-law had considerable influence over their daughter-in-law's behaviours and practices, including her maternal health and health care. The husband's role tended to be inferior and more supportive and advisory. An understanding of their social obligations of respect and compliance followed the recognition of the mother-in-law's knowledge and experience: "The mother-in-law

will come, she will know [when it is time to go to the hospital] because she has given birth to four children.” Although this created a relationship of dependence for primigravid women, the benefit was social capital gained from having the support of an experienced and knowledgeable woman. A similar relationship determined decisions about the choice of delivery facility:

I: Who took you to the hospital?

R3: My mother-in-law took me there.

I: Were you asked where you would like to?

R3: They asked me. My sister went to [hospital] B, in ‘Dublin’. So, I said, “register my name in this [hospital] B”. Then my mother-in-law said that her daughter delivered there in [hospital] D, “so let [the delivery] happen there, it’s good”.

(nbdeapuhin0001, Hindu, 19 years, one birth)

In this case, although both women knew a suitable hospital, the mother-in-law’s social superiority enabled her to make the final choice. One explanation for the power that mothers-in-law have over health care decisions regarding their daughters-in-law is the responsibility they assume when they accept her into the family. Having left their natal homes, newly-married women are no longer under the care of their mother. Responsibility for ensuring the daughter-in-law’s maternal health and wellbeing passes to the extended family. At the same time the natal family are liable to scrutinise the in-laws’ behaviour and actions:

R2: If something [bad] happens later then [the in-laws] will catch us.

R1: [They will say] “That this happened because of you”.

R2: We will have to listen to ‘two things’<sup>2</sup> (be told off).

R1: They are the elders, whatever they say we will *have* to listen.

R2: Now, the in-laws are scared. Because they are scared that our natal families will say something...that is why they are scared. This is the *only* fear that they have.

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<sup>2</sup> *Do baat* is a phrase which translates as ‘two things’ but is often used to refer to things people say about others. Here, she means that the in-laws might taunt or shout at her.

R3: And now our natal family also can't do anything...

R1: Yes.

R3: ...because the in-laws will shout. Their ... now I am their *amaanat*<sup>3</sup>. Now [our natal families] ... according to them, they can't do anything.

I: Okay, and the in-laws and natal family ... can you share with me? Will there be a fight because of this issue?

R2: If there a problem happens [during the delivery]...

I: Yes?

R2: ...if there is some trouble then what will they [the in-laws] say? That it was the mother and father's fault. That is why this is the issue.

I: So are you trying to tell me that there will be blame-games ... "that it happened because of you"?

R2: That is why we don't want [to go where we prefer] ... the child is theirs (the in-laws'), so we will support them, that is why.

(nbcprhin0001, Muslims, 18 and 20 years, both primiparous)

There are both constraining and enabling elements to this relationship. Younger women have relatively little autonomy and are expected to accept a mother-in-law's decisions. They run the risk of blame for a wrong choice. On the other hand, they also have someone more experienced to 'take responsibility' for their health. Not all mothers-in-law imposed decisions on their daughters-in-law. Some interviews indicated that mothers-in-law sometimes gave in to their daughters-in-law's preferences, to satisfy them.

Typically, couples who had started their own family would, if they could afford it, set up their own home. In nuclear families, maternity care decisions were made jointly between husband and wife. Despite the opportunity to participate in decisions in nuclear family structures, some women said they had to ask for their husband's

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<sup>3</sup> The term *amaanat* (lit. 'deposit') as used here refers to the understanding that these women are under the care of their in-laws or 'theirs for safe-keeping'.

permission or seek his approval before choosing a health care provider. Without in-laws or other relatives to intervene, these women often exercised greater influence over health care decisions. Older women had acquired more knowledge and experience, which helped them gain status and agency. For these women, autonomous decision-making was relatively easier, although sometimes required them to assert themselves if their preference differed to their husband's:

I: Then who decides? Who decides which hospital to go to?

R: Both of us take a joint decision.

I: Both?

R: Yes.

I: Okay. I asked because he knows people [in hospitals]...

R: No, both of us make a joint decision. He is of the opinion that all this is better at a BMC [municipal] hospital that is why he advised me to go to a BMC hospital. But this time around I acted stubborn since it looked like I would need an operation [cesarean]. I said that I didn't want to go to a BMC hospital, I only wanted to go to a private hospital. Because of this the delivery was in private this time around.

(nbddedprmar0001, Hindu, 35 years, five births)

Women living in a nuclear family without the support of extended relatives, and those with several children or young infants, found it "very difficult" to visit health providers. Sometimes they forfeited or delayed care-seeking (such as initiating prenatal care in the fifth or sixth month of pregnancy) until they could find an opportunity or they experienced symptoms of complication.

In a focus group discussion with women who had experienced one or more home births, one participant recounted being home alone at the time of labour, though she had registered her pregnancy at a hospital. Her husband returned from work while she was in advanced labour. Her *khala* (mother's sister) was called but took time to reach her. Because there was no-one with her, she did not go to the hospital and delivered at home. The *khala* called a *dai* who lived in the same community and came to manage the birth. The labouring woman was Muslim, had five years of

education, and lived with her husband and four children in a socio-economically deprived informal settlement. The fact that she had registered at a health facility suggested a planned institutional birth. However, her inability to travel alone or to mobilise social support at short notice prevented her from travelling to the facility in time for the birth. Evidently the local *dai* lived near enough to be able to attend.

Because of the increase in institutional delivery across all socio-economic classes, demand for *dais* appeared to be in decline. Other focus group participants said that they had called a doctor or a nurse to attend a home birth in towns outside Mumbai. They explained that home births were not primarily motivated by an aversion to hospital care or fear of mistreatment:

I: You did not like to go to hospital?

R1: No, [actually], I like to go. But the thing is that, no-one stays at home, not even the men. They are mostly outside. They say that if we need something, just go and call the [*dai*], they will come.

I: Now, most of you have said that there was no-one with you at home, and that either you or your neighbours called the *dai* and then you delivered at home. So apart from this, are there any other reasons [for choosing a home birth], like you don't believe in doctors or you don't like to go to hospital?

R1: No, no. Why shouldn't we believe in doctors? It's not like that.

(nbdehbr0001, focus group discussion, Muslim women with experience of home births, 28-35 years)

Some participants refuted the idea that a pregnant woman was ever entirely alone or without a relative or neighbour to help her reach the hospital. Rather, the main reasons they gave for a home delivery were related to comfort and convenience, a practice that might have been further motivated by the knowledge that a *dai* or other experienced individual could be summoned, often at short notice:

I: Ok, so, everybody thinks that we should go to a hospital?

(Several participants agree in the background, but the voice of R2 is very prominent)

R2: Yes, we should go

(One respondent seems to be smiling ... and gives no answer)

R3: Now, if we call [a doctor or health worker] to our home, they do come, we believe them, so we call them (many respondents speak simultaneously).

R6: Nobody was present at my home [at the onset of labour], so I delivered at home.

R2: No, *bhabhi* (sister) it's not like that. If you had called the neighbours they would have [helped you] ... in our lane ... if you tell the neighbours [about the pain], then they would get ready and take you to the hospital ... It's not like that ... Now, that aunt who died, she only took me to the hospital at the time of my girl child ...

R3: Yes, even I faced this kind of pain. [Suddenly], it started hurting so much, so I delivered here at home only. I did not have enough time to go to...

R2: So, you people became helpless, and remained at home only ... But I say that it is not like the husband is not at home or that nobody was available to take you to hospital. It doesn't happen like this.

I: Ok, that means you were with ... you would have called your neighbours, but it hurt so severely, so you-

R2: At the time of my youngest daughter, what I told you ... I had been suffering pain for two-two, three-three (several) days. I did not stop doing the housework. I did all my work – I mean washing clothes, utensils, cooking food. I did everything. And the day I delivered, some guests arrived at home. So, I cooked for them, made them eat. But when I could not tolerate the pain any more, I told my Mum, “please take our guests away, I am not well”. So, my mother went out to drop the guests ... at that time only the fluid started leaking out (my waters broke). So, I called a woman who lived opposite me ... She asked me if I needed a rickshaw. I said, “you won't even be able to take me to the road”. Then, after hardly 15-20 minutes, I delivered a baby girl. What would have been done? You would have only managed to call a rickshaw by that time.

(nbdehbr0001, focus group discussion, eight Muslim women with experience of home births, 28-35 years)

An initial observation from this excerpt is that access to social support (in this case, for women requiring urgent help) varies in informal settlements. This might be influenced by several factors, such as the length of residency in the area, local social cohesion, and the opportunity to build ties. For example, R6 was a 30-year-old uneducated woman who had lived in the community for three years, while R2 was 35 years old, with secondary education, and had lived in the community for “a long time”. R2 would be expected to have developed stronger social ties with neighbours. Even so, she refuted the other women’s claims to have had no support, arguing that local social support networks are always present and easily accessible. Despite her advanced pregnancy, R2 continued with her normal social responsibilities (hosting guests), which resulted in her mother’s absence and the need to seek support from a neighbour. In other interviews, some women reported that, if they experienced a health problem and lacked social support, they would prioritise their own needs and act, abandoning their domestic work. As one woman complained, “no-one will feed us while we sit quietly”.

Whether the woman in the excerpt did or did not have access to social support, it offers some insight into the ways in which they reflected on their circumstances at the time of requiring health assistance and their explanations of why they delivered at home: R2 and R3 because of the sudden onset of labour, and R6 because she had no support and could not leave home alone. Despite the apparent consensus on the importance of institutional delivery, each woman justified the reasons for her home delivery, which they all argued were out of their control. Interestingly, after the other participants had left, R6 and two other participants ‘admitted’ that their real reason for delivering at home was a fear of the hospital, the possibility of undergoing episiotomy, or the presence of a male obstetrician. It might be that by pinning their inability to reach a health facility on rapid labour or weak social ties, they sought to avert personal blame.

Constraining conditions produced responses including various strategies and actions related to care-seeking decisions. They included adapting, managing multiple roles, compromising on care, and mobilising resources.

#### **8.4.3.1 Mobilising resources**

When utilisation of maternity care was limited by financial or social constraints such as poverty, time pressures, or limited decision-making power, women sometimes sought to increase their access to material or social resources. The main sources were relatives and other individuals in their social network. Types of resource included additional money, childcare support to allow the woman to spend time outside the home, and seeking someone to accompany her to a health facility.

Women who were dissatisfied with their current level of care and wanted to switch to an alternative, preferred provider often had to negotiate access to further resources. Women also negotiated when they wanted to access a source of health care that was currently socially or economically inaccessible, such as a preferred provider whose fees were higher, or a health facility located farther from home. In these instances, additional financial and social resources might be required. For example, when one woman from the poorest economic group in her fourth pregnancy experienced problems registering her pregnancy and became dissatisfied with the care provided at a nearby municipal maternity home, she and her husband borrowed five thousand Rupees to facilitate access to an alternative, private practitioner. Another, uneducated woman from the medium wealth quintile borrowed five hundred Rupees to pay for her delivery at a municipal hospital:

**I:** So, you were able to manage the expenses which were occurred at the time of delivery?

**R:** What?

**I:** Did you take loan or borrow money from someone?

**R:** I took [money] from the manager (of her husband's workplace).

**I:** From whom, from whom?

**R:** The manager.

**I:** Which?

**R:** Now there is some manager who, if something happens, then he lends us money and we pay him back in instalments.



(nbddedpuhin0002, Hindu, 28 years, four births)

Despite the financial implications of debt for the family, that some borrowed money suggested that they perceived the benefits of hospital delivery care and were willing and able to do so.

Women sometimes negotiated their responsibilities in the home in order to travel, or sought additional social support when they needed someone to accompany them to a health facility. Although most were able to express their preferences and the need for support with their family, women of lower social status, such as young or primigravid women, found it difficult to negotiate resources and influence decisions. In one focus group discussion, when asked about her role in choosing her maternity care provider, one young woman recalled,

They asked me. My sister went to B in [eastern suburb]. So I said I wanted to register my name in this hospital. Then my mother-in-law said that her daughter had delivered in D, so the delivery should happen there.

(nbdeapuhin0001, Hindu, 19 years, one birth)

#### ***8.4.3.2 Adapting to constraints***

A consequence of the inability to access or negotiate further financial or social resources was the need to adapt health care-seeking actions to the family's existing conditions. Women explained this in terms of having to live within their means, manage multiple responsibilities in the home to access services, and compromise on care.

##### ***Living within means***

Limited income and difficulty in meeting household expenses meant that families had to find ways of living within their means. Ensuring household needs were met had an impact on women's health care-seeking. The financial capacity of the household often depended mainly on the husband's income as the main earner, and had to be managed carefully to meet regular expenses such as food and rent. Given that one "can only spend according to one's income" and that the cost of living in Mumbai was relatively high for families that had migrated from towns and villages elsewhere in India, families had to budget their expenditure. Being poor made

women aware of the limitations on their choices. Rather than abandon health care, however, most devised ways of accessing a provider that was within their means. In some cases, women preferred to believe that any health care was better than nothing.

### *Managing multiple roles*

Women had multiple responsibilities in the home and income generation. Being pregnant did not involve a substantial change in roles and responsibilities and women were explicit about their responsibility for keeping the household functioning. Families considered the effect that health-seeking might have on the household, which was taken into account when making health care decisions. Often, the needs of the family were emphasised and women prioritised their obligation towards domestic responsibilities over their health needs. One woman who had consulted a local private doctor for troubling symptoms after conceiving within a year of delivering twins recalled:

[The doctor] said, “You will have to stay here [in the hospital] only for about a week. You need complete rest this time.” ... So, this can’t be done. A housewife should remain at home no? How will she leave the children at home?

(nbddedprhin0002, Muslim, 26 years, four births)

Women often had to manage multiple roles so that their pregnancy and care-seeking caused minimal disruption to the household. Since women from higher socio-economic groups were better able to assert their preferences and mobilise resources, they could choose from a wider range of providers, including the private sector. This meant that they were able to select better quality providers. Conversely, the selection process was more difficult for poorer families because of their need to choose within a limited sphere of access. They did this by compromising on care.

### *Compromising on care*

Accepting the inability to improve one’s situation, usually because of poor financial conditions, often meant compromising on health care. In these situations, most women came to terms with their reality, understanding it as, “you have to win some and lose some, no?” Others looked for positives:

I feel that government hospitals are good enough. Only those people who have the money [access private care] ... we are poor, where will we get 10-15 thousand Rupees from? People who have money go [to private hospitals].

(nbddedprmar0003, Hindu, 30 years, three births)

When families were unable to mobilise resources, women adapted their care-seeking to their existing means: “if there is money I go and if there is no money then I don’t go.”

If I am helpless, then I have to believe. Then even if anybody says anything, then also I will have to listen. I will have to do it. There will be fear no? Whether he [the doctor] is good or bad. If we get a good [doctor] then he will do good and if we do not get a [good doctor] then he will do bad.

(nbddedpuhin0002, Hindu, 28 years, four births)

Compromising involved a range of methods to adapt to limited resources and avoid excessive expenditure. These included delaying care-seeking, budgeting or rationing care by choosing an affordable provider, or switching providers in the case of escalating costs. When families were unable to mobilise resources, women adapted their care-seeking to their existing means:

Now, every time I visit the *dawakhana* (government dispensary) they change my medicines. They prescribe medicines worth 350 Rupees. Then I have to buy these. Now during this week there was a little financial problem at home so I didn’t buy any of the medicines for this month. We live in a rented room, have to pay 1500 Rupees and the deposit is 15,000 Rupees, 20,000. These are all the expenses for this week therefore 2000 Rupees is not sufficient. But still I have to manage everything somehow.

(nbcpapuhin0002, Muslim, 19 years, first pregnancy)

## **8.5 Managing the health care encounter**

A key phase of manoeuvring involved interactions with the health care system. Almost all of the women interviewed in the study had experienced some form of institutional maternity care (even those who had experience of home birth), through either prenatal visits or delivery care. This was not restricted to the doctor-patient

encounter, but included multiple types of interaction with infrastructure and services, levels of staff, processes and procedures (administrative and clinical), and other service users. Reflexive monitoring of these multiple interactions shaped women's care-seeking and influenced their action both during and after their encounters. In the following sections, I describe three aspects of women's interactions with the structured setting of institutional maternity care in which reflexive monitoring formed a key part of the manoeuvring process and in producing responses to them: experiencing health care, navigating the health care encounter, and reconstructing health care.

### **8.5.1 Experiencing health care**

Participant narratives indicated various ways in which women experienced and interpreted their interactions with the health system and maternity care, as well as ways in which they sought to act within them. Accounts of their experiences varied according to their health status, the sector and provider being used, and the type of service being sought. Health facilities, especially public hospitals, were large, busy, or unfamiliar places; procedures before, during, and after consultation were often lengthy and complicated. For all women, especially those with little experience of seeking care, this was often a challenging environment. As one young woman said:

... it is true that there [in government hospitals] you need to run around a lot, they call you once to test your blood, then to collect the report, and then for a check-up – again they will call you for a check-up. This is what they do. That is why you face a bit more of a problem there.

(nbcpapuhin0002, Muslim, 19 years, first pregnancy)

Being a 'client' of a health facility was not always the same as being a 'patient'. Registering a pregnancy or using prenatal services in government hospitals meant having to "run helter-skelter", fill in forms, obtain diagnostic tests, and queue for consultations. One woman said, "There is a lot of 'being pushed around' type of work to be done". This made using public sector services time-consuming and cumbersome. Although being admitted for delivery absolved women from much of this 'bureaucratic hurdling', relatives became responsible for other routine tasks such

as paying fees and obtaining prescriptions. In comparison, private facilities were described as more organised and ‘customer-oriented’.

A common theme in many focus groups and interviews was that, in the institutional setting of the medical facility, pregnant women were redefined as bodies that required professional monitoring and intervention by a health professional. In a sense, they were bodies to be intervened upon through health care practices. This unequal relationship afforded medical practitioners greater power to determine the context and content of the medical encounter. Some women were subjected to forms of poor care and mistreatment, including refusal of services during labour, verbal and physical abuse. Although women often reported being satisfied with their experiences with medical staff, several accounts showed how some were subjected to undignified medical treatment:

R: One of the women was having severe pain in the belly, I think her water broke, so the doctor asked her what was happening. So she said, “my waters broke and I think it’s time for my delivery.” He made her lie down on a bed and the doctor inserted his hand (participants shows 4 of her fingers and imitates the doctor checking cervical dilation) down there to check! We were all so tensed to see what he just did and feared that the doctor would do the same thing to us! But even then he talks to all of us with love (politely).

I: Okay.

R: Earlier when I visited here, there used to be this woman there who was very unpleasant and rude to me, always yelled. But now whoever sits there talks politely to us.

(nbcpapuhin0002, Muslim, 19, first pregnancy)

The excerpt suggests that some women had little control over what happened to them in the consultation room. As a young woman who had only recently started experiencing health care, the focus of her concern was more on how the doctor’s actions transcended culturally-gendered norms of behaviour and professionalism and caused great fear. Her young age and relatively low opportunity to speak out might explain why she did not seem to criticise the doctor for his unprofessionalism, not respecting the woman’s privacy, or for disregarding the impact his behaviour might

have on the waiting women. Moreover, she juxtaposes this with the way he “talks politely” with the women. It is also important to note that despite this experience the woman continued her prenatal care at the same facility, rather than seeking to switch to another. Although elsewhere in the interview she expressed her wish to access private sector care because of the better standards private providers offer, her poor social and economic conditions prevented her from doing so.

Anyone was susceptible to experiencing substandard care or offensive provider behaviour. However, more experienced women reported responding more vociferously. In one example, a woman recounted events after being admitted to a government hospital for childbirth and suddenly going into labour and giving birth in the toilet:

When I started crying out loudly and screamed loudly, there was another woman in [the bathroom]. I shouted loudly, I said, “just tell the *mausi* (‘aunty’, older female attendant) ... Then the *mausi* came running, instead she shouted at me only... I said there was no one nearby, what could I do, about the bathroom [her need to go to the toilet]? She said you should have done on this [the bed] only ... I said even if I would have done on this, even then you people would have shouted at me. [She said] “If you wanted to give birth like this then you should have given birth in your own bathroom at home!”. Like this she said, in government. That’s why [one] feels scared going to a government [health facility].

(nbdedpphin0002, focus group discussion, women with mixed maternity experience)

All users of maternity services anticipated a degree of ‘bureaucratic hurdling’, excessive time spent queuing and waiting, or hostile interactions with staff at some point during their passage through pregnancy and childbirth. This was especially so at government facilities. Besides the general power imbalance between health staff and clients and general exposure to mistreatment and discrimination, certain groups were perceived to be more susceptible to than others:

**R:** I said just that those *ayahs* there say really dirty things and one feels bad about it. They say those things ... at least during that time [pregnancy] they shouldn’t say such things because during that time the woman is going through so many things and these *ayahs* are on a different tangent altogether. So is she supposed to suffer that

[the labour pain] or listen to these things during that time, eh? They don't understand a thing. Because of this I think Muslim women may go mostly to private.

**I:** Why so?

**R:** Because they [hospital staff] say more to them [the Muslim women]. Moreover they have more children, because of that you can never say for sure. And they don't get the operation [sterilization] done, no? Because of all this maybe they [the hospital staff] say things to them occasionally.

(nbddedprmar0001, Hindu, 35 years, five births)

This account shows how women experience and reflect on the attitudes and behaviour of hospital staff towards patients under their care, and how their potential to produce aversive action, in this case, avoidance of public sector health services. Women who seek maternity care see themselves as in a vulnerable state and, when in discomfort or pain, deserving of compassion and care. The account also points to other social and cultural divisions and hierarchies in Indian society, and how the existence of socially marginalised groups create conditions that give rise to poor health care experiences. It is important to note that *Ayahs* – the hospital cleaners and helpers – are positions filled by people from lower status castes and social groups, not dissimilar to many of the women seeking care at the facility. However, the excerpt above illustrates how Muslims are criticised for restrictions under the Islamic faith that produce certain constraints of family planning. The prohibition on the use of contraception is understood as incompatible with the global, medicalised model that emphasises rationalised decision-making and controls over individual behaviour and family size. Muslim women are, therefore, considered irresponsible or deviant because they have more children and refuse sterilisation. As a result, they expose themselves to blame and criticism in the form of mistreatment.

Responses to the low quality treatment and insults of some health care staff varied. Poor socio-economic status made it difficult for women to stand up for themselves or to simply switch to alternative care. In these circumstances women chose ways to pacify the encounter:

And they [the staff] say, “for what reason do you sleep with your man?” We go quiet listening to their talk ... for this reason we shut up. They talk to us like this. Now, if they didn’t talk like this then ... if they come a little, take care of us, and talk to us a little, things will happen smoothly. But, if they talk like this then we will become quiet.

(nbddedpphin0001, focus group discussion, women with mixed maternal experience)

The excerpt suggests that these women were unable to defend themselves against insults. More importantly for the theory of manoeuvring, it also shows that all women reflected on the circumstances in which they experienced different types of health care, balanced their judgement on the sphere of access and risk of abuse, and used this to decide appropriate forms of action. An unintended consequence of situations like these, where women feel forced to tolerate mistreatment, is that the abuse of disempowered women is perpetuated.

### **8.5.2 Navigating the system**

One response to the types of experiences of health care described above involved a concept that I termed ‘navigating the system’. Navigating the system meant using one’s knowledge of the system and employing various strategies to move through it and to make the experience and outcome more efficient, positive, and successful. These included both administrative or admission procedures and medical encounters.

Women developed their ability to navigate the system through their cumulative experiences such as repeat prenatal care visits. Women who had more childbirth experiences had a greater capacity to navigate successfully. Being knowledgeable about the system helped make navigation smoother and more efficient. For example, since hospital outpatient services operated on certain days and on a first-come-first-served basis, knowing the timings of the maternity services helped women to plan their visits to coincide with consultations and minimise waiting times. Similarly, arriving early at a health facility and joining the queue before consultations started was useful, especially in large public hospitals, “because there is a huge rush over there. And then to get done with so many patients ... if I go early then it is done early.” Doing this helped avoid spending more time than necessary in the health facility.



Some women sought social and practical support by enlisting the help of female friends and relatives. Besides providing company and moral support during hospital visits, a knowledgeable person could orient the woman and show her how best to navigate the facility and services. One participant recalled how her neighbour had, “showed me [the hospital] and said, ‘you will find the registration paper here, you will find that paper there’. She explained everything.” The women who received this informal ‘hands-on’ learning improved their own navigation skills for future visits. Another benefit was that certain tasks could be shared:

If you are in one queue and your mother-in-law is in another queue, then you can take medicines from one queue easily. If there are two people, then your number comes up quickly. That is why somebody should be there with you.

(nbdedprhin0004, Muslim, 27 years, two births)

Knowing someone who worked in a health facility was also useful because they could be used as direct access to useful information and provide “a little bit of help” to navigate services because “they know the hospital the most, what is done and in what manner.” A few women reported being allowed to jump queues if they knew the nurse in charge of managing the waiting room queue:

Those who know someone at the hospital go inside without queuing. I saw that this happens ... patients who are known to the staff are taken inside before their turn and those patients who have been waiting since eight in the morning go inside at eleven or twelve in the afternoon.

(nbdedprmar0003, Hindu, 30 years, one birth)

A final benefit was that being accompanied could also offer some protection from mistreatment from hospital staff. For example, some women took their husbands to hospital appointments. They often took responsibility for admission and payment, and accompanied their wives in prenatal consultations. This was, however, rare. Furthermore, hospital norms prohibited relatives from entering the delivery room, preventing them from monitoring the conduct of the obstetrician and nursing staff.

In this and the section above it, I have described some of the unpleasant or hostile circumstances in which women were unable or unwilling to exercise their agency, and others where they were. Following on from the latter, some of the women's narratives indicated different ways in which they, together with close relatives, often challenged the health care system. These included questioning medical advice, negotiating medical intervention, and being assertive.

#### **8.5.2.1 *Questioning medical advice***

When a medical diagnosis or interpretation of a symptom did not fit the family's lay or experiential knowledge, they sometime questioned the doctor's knowledge or advice. One action that resulted from questioning medical advice was to seek alternative opinions:

There was no chance at all for the baby to come out, so she suggested that we should get an operation [caesarean section] done. We asked at a lot of hospitals ... I had asked the other doctors from private ... the doctor where he [my husband] works on his other job during the nights. My husband asked him too and even that doctor said, "No, you will have to get an operation done for her. There is no other option."

(nbdedprmar0001, Hindu, 35 years, five births)

Possible explanations for questioning medical advice included the level of distrust women had towards some providers and the motivations for their decisions, and if the recommended action was likely to cause considerable inconvenience to the household, such as requiring the woman to be admitted to hospital for several days. Either way, it provides further indication that some women and families were capable of acting purposively in their interaction with providers. Not everyone accepted the doctor's proposed interventions and people consulted other providers to check the diagnosis and prognosis.

#### **8.5.2.2 *Negotiating medical intervention***

Another way of influencing the type and timing of a medical intervention was to negotiate with the practitioner. As mentioned above, professional health knowledge and appropriate medical interventions were not necessarily accepted without question. Some women used their own knowledge or sense of ownership of their

own health to negotiate alternative action. For example, in the excerpt above, after verifying the doctor's understanding and recommendation for caesarean section with other local providers, including one known to them, by agreeing to stay in the care of the private clinic overnight, the provider allowed more time for a normal delivery: "... the doctor came herself. She said, 'If you don't get contractions till the morning then I will do the operation, otherwise I won't'."

It is entirely possible that the provider judged that the woman's condition was no longer an emergency and that delaying the cesarean section overnight would not increase risk. However, seeking advice from other providers demonstrated the couple's aversion to operative delivery and the potential for them to go elsewhere. Other interpretations of the doctor's willingness to delay surgery include loss of revenue or, perhaps more likely, to avert the risk of the patient being exposed to risk by a less scrupulous provider.

#### **8.5.2.3 *Being assertive***

Another way in which women sometimes exercised agency to influence their interactions with health care providers entailed being assertive during medical encounters. It is worth mentioning again that women seemed relatively disempowered in hospital settings. Medical staff took decisions and behaved in ways that might have been influenced by their own interests, not necessarily what satisfied the women's expectations and wishes. Women or accompanying relatives usually asserted themselves in response to an unfamiliar, unexplained, or frightening medical situation in which they feared for the mother or baby. These included experiencing sudden pre-labour pain and birthing complications for which the clinician advised referral to the municipal tertiary hospital. In the latter case, the participants were fearful of the hospital. According to one participant, "Everyone says that once a patient goes there they don't come back [alive]". Traumatic personal experiences in health facilities had powerful negative emotional and psychological effects, which often manifested as fear:

My brother died there. Since then I am scared. My father's sister also died there so, that's why. He [brother] was almost cured but then he died. He was to come home

the next day, but then two days before, he died. Also, my father's sister died there too. Since then I am very scared. So, the people who go there, they die.

(nbddedpuhin0004, Hindu, 22 years, four births)

Families' lack of trust in providers and a willingness to challenge medical knowledge and advice led them to take extreme measures to avoid a perceived risk. Being assertive meant taking matters into their own hands. However, since this usually meant taking a decision that went against medical advice, it presented the possibility of other risks. People responded in different ways depending on their understanding of the health condition and their perceptions about the current provider's competence to manage it. They typically conformed to one or more of four patterns: questioning medical advice, negotiating the medical intervention, insisting on a course of action, or refusing referral.

When women or families had their own understanding about the woman's health status and a strong preference for a particular course of medical intervention, they insisted on them. This meant that some women "acted stubborn" to get their way, even if the preferred action was risky. The following interview excerpt illustrates the use of this assertive action to insist on being allowed to give birth at a preferred municipal maternity home, even though it lacked the facilities to perform caesarean section:

R: I told them [at M] to let the baby be born here. I would rather die here than go to F ... I told them, so they conducted the delivery there only. I am scared of the hospital ... if I go there [F hospital], I am scared of having a caesarean.

I: You are scared of a caesarean?

R: Yes, they tear the abdomen and remove the baby.

I: But what if something has happened to the baby?

R: Nothing happened.

I: You felt that your baby would be delivered normally?

R: Yes, I knew that the baby would be delivered normally because all my three [previous] babies had been delivered normally.

I: Three babies were delivered normally, so you thought that the fourth baby would also be delivered normally?

R: Yes, I felt like that, so I didn't go.

(nbddedpuhin0004, Hindu, 22 years, four births).

Although the woman knew both options were risky, she claimed to trust her own understanding of her health condition since all of her children had been delivered normally in public sector hospitals. This, combined with her fear of caesarean section and of being treated in the large municipal hospital, led her to insist on delivering normally: "I told them [the doctors], 'You just look [check] properly, and do it properly'."

Fear of treatment or the potential for poor outcomes at larger hospitals resulted in some families refusing to accept a referral:

Since the situation looked like there would be an operation, I said that I didn't want to go to a BMC (Municipal) hospital, I wanted to go nowhere else but a private hospital ... they said that it is critical and then I ... told him [my husband] that I won't go to hospital M ... they send their patients directly to hospital F. [I said], "I don't want to go to hospital F."

(nbddedprmar0001, Hindu, 35 years, five births)

Other forms of insisting included demanding discharge from a health facility when the medical treatment was deemed inappropriate or believed to be causing complications. One woman reported perceiving a problem after being administered an injection to induce contractions. The injection caused sudden labour pains, which, because her previous three deliveries were relatively painless, she associated with a complication:

The doctor administered an injection. Once the injection was removed there was a problem. After that, my husband started removing my name [discharging her from the hospital]. I told him that I was going through a lot of trouble, nothing like this

had ever happened! Then I said that I would go somewhere else. I was having trouble with pain ... I was crying at that time.

(nbddedprhin0001, Muslim, 28 years, four births)

Since this experience didn't fit with the woman's understanding, she interpreted the pain as a complication, which she understood had arisen as a result of the injection. That this led her to go somewhere else suggests that she may have considered the doctor incompetent or the medical intervention inappropriate.

### **8.5.3 Reconstructing experiences**

Women continuously reflected on their conditions and experiences of care-seeking to make sense of events and encounters, and to inform subsequent care-seeking decisions. Many had accumulated considerable knowledge and experience through their repeated visits to health facilities, encounters with the medical system, and interaction with providers. Most prominent were their interactions with health facility staff and maternity services, which they reflected on in both positive and negative ways. They assessed health care in terms of the capacity and comprehensiveness of facilities and services, provider characteristics, competence and behaviour, effectiveness and efficiency of treatment, and health outcomes.

There they investigate everything properly. I mean the stomach's ultrasound is also done. Through that [they] come to know whether the child is proper or not ... that's why I had gone.

(nbddedpphin0002, participant attributes unknown)

Provider characteristics included knowledge and competence, professionalism, popularity, and reputation. Women considered provider behaviour an important aspect of their experience, especially when they had been subjected to verbal and physical mistreatment:

Because you [government hospital staff] say these things to women during such a time ... already those women ... already they are in danger and even then you say these things and it becomes worse. So how is the woman supposed to find strength at a time like this [delivery]?

(nbdedpumar0001, Hindu, 25 years, three births)

Knowledge of the services provided combined with an understanding of maternity and the perceived benefits of different interventions helped evaluate them. This, in turn, influenced judgements about the success of health care choices and indications about how to proceed.

So when I went there they made me run for 3 days, 4 days, [they asked me to] bring this, bring that, his ... I even took it [there] from here, within one day! I came walking from there, I didn't have the money for transportation, so from there I came again and they had asked for the birth certificate of the second [child] so I took it. So after that they asked me to come the third day again, and then I was tired, my condition became bad. When I walked, at that time my legs pained. Because of that I stopped going there.

(nbdedprhin0001, Muslim, 28 years, four births)

The above excerpt illustrates the struggle against the bureaucracy of health care, in this case the two-child norm, which ultimately ended in discontinuation of care at the public health facility. Many women believed that government health facilities imposed a 'tax' on those who sought maternity services for pregnancies beyond their second child. However, staff reportedly often referred to the expense as a 'fine', which may have been used as a strategy to encourage women to practice family planning. Although it is not clear whether communication problems or the woman's evasion was the actual cause of her having to produce more certificates, the inconvenience and its effect are evident. Moreover, the case shows how the woman's interpretation of the challenging circumstances and poor experiences with the health provider led to the decision to switch to an alternative.

Women also used their experiences of care-seeking at both government facilities and in the private sector to share information and to advise others. In the following excerpt a woman shared her observations while seeking care in a municipal hospital, with her sister-in-law advising her to avoid the public sector:

I told her rather than going to the municipality [hospital], it's better to go private. It will be costly but go to private. Because I have been to municipality and seen it. I

said this is what happens at municipality now, so out of fear she said, “I will not go.” So she went to register her name in a private facility.

(nbdedpphin0001, participant attributes unknown)

It is likely that seeking and providing information within and across social networks modified the level and types of knowledge available in each one. Introducing new knowledge from recent experiences or passing it on from one network to another increased the quantity and specificity of information available to other women. This may have included information on which providers were ‘good’ and which to avoid. What this implies is that knowledge and information available to network members was constantly changing.

#### ***8.5.3.1 Defining satisfaction***

Reconstructing served to identify and consider positive and negative aspects of care and expectations as a way of defining satisfaction. Defining satisfaction meant considering both clinical and non-clinical experiences of health care. For some women, satisfaction meant receiving effective medical treatment. One discontented woman reportedly told a doctor, “I am not getting satisfaction. I am not satisfied with my treatment and your medicine.” For other women, the nature of interaction with hospital staff was important: “ [...] the main thing is that if the doctor comes more often than the nurse during the delivery then the patient feels more satisfied.”

Other women sought to explain the reasons for positive and negative outcomes from their experiences of health care:

The delivery was done well here [U] too! When those people touched [gave abdominal massage] the child was born within five minutes ... Even here [T]! I mean it was done properly here too. Where I went earlier, it is nice when they touch during the pain.

(nbdedprhin0001, Muslim, 28 years, four births)

Families evaluated their experiences by verifying provider practices against the outcomes of health care. In short, if the outcome was positive, the provider could be trusted. One participant explained that her in-laws had selected a particular hospital



for her delivery because they trusted the doctor. When questioned about why they had so much trust, she replied:

Because their daughter's son was also born there, they trust that if we register our daughter-in-law's name here, then they will give the proper medicines. They look after [their patients] well, that is why they trust them.

(nbcpaprhin0001, Muslim, 25 years, one births)

Depending on their experiences and the degree of satisfaction with their health care experience, women either sought to have their subsequent care with the same provider or took action to seek an alternative, such as switching provider or abandoning health care.

Discontinuing care as a result of dissatisfaction is an unintended consequence produced through the continuous monitoring and evaluating of health care experiences. That is, the original motivation and resulting action is unsuccessful and the woman abandons the social institution whose very role is to protect her maternal health and ensure a safe delivery.

One woman reflected on her preferred facility, where she had previously had a positive experience.

I would have gone [to the municipal peripheral hospital] because in that hospital there are facilities. I've seen that so many patients ... they get operated on there and stuff. If I had registered at hospital D, I would have gone there.

(nbdedprmar0001, Hindu, 35 years, five births)

This excerpt is an example of the process of social reproduction in manoeuvring. As a knowledgeable individual, the woman is able to reflect on her situation and her likely experience of choosing a particular form of action. In this case, her understanding that the municipal hospital has the capacity to respond to medical emergencies but that, by not registering her pregnancy there, she is ineligible to deliver there. Her action to not go effectively reproduces the structure of her social situation.

Satisfaction with care encouraged continuation with the same provider, even if there were other providers nearby. For example, one woman who gave birth at a large government hospital, then moved to another Mumbai suburb, chose to use the same hospital for her subsequent maternity care even though it required a longer train journey:

I: [The hospital] was near [to your previous residence], but it is far away from here?

R: Yes, it's really far away from here.

I: So why did you go there again?

R: Just like that. [My husband] said that he didn't know [another hospital] here. We had recently moved here (another suburb in Mumbai)...

I: Yes, but that was during the first child, right?

R: No, during the second child. We were new here, so we did not know anything about this place (unfamiliar suburb), where everything was and all that ... [I] liked it ... we didn't go anywhere else, only to that [same] hospital ... it is good.

(nbddedprmar0003, Hindu, 30 years, one birth)

In contrast, dissatisfied women told others about their experiences, advising them to avoid the provider and seek an alternative:

... it had been four months since I registered my name, five months passed. So I told her. I told her, "rather than going to the municipality it's better to opt for private. It will be costly, but go to private because I have been to municipality and seen it". I said this is what happens at the municipality now. So out of fear she said, "I will not go", so she went to register her name at a private facility.

(nbddedpphin0001, focus group discussion, women with mixed maternity experiences)

The accounts and narratives presented in this section aim to illustrate how women reflected on, interpreted, and acted on their situations and the conditions for health care in a field in which the power imbalance is tilted heavily against them. It showed ways in which some women and families were limited in their ability for action, or

chose not to exercise it, and how others had greater ability to evaluate and challenge their circumstances. Examples of this included questioning and seeking alternative opinions to negotiate interventions and outcomes.

I end with a summary of the theory presented in this chapter. The theory of manoeuvring is a social practice that women, with members of their family, engage in through pregnancy and childbirth. Manoeuvring illustrates ways in which women experience the interaction of social structures and agency in different contexts, in the home and at health care facilities, how they reflexively monitor these experiences and how this reflexivity influences further action, and its effect on prevailing structural conditions. This process either reproduces regularised patterns of health-seeking and interaction with family health care providers or results in or revised or new practices.

Manoeuvring comprises three interrelated stages of action: exploring the options, purposive selection, and managing the health care encounter. Primary motivations for engaging in manoeuvring include inequitable socio-economic conditions, and a concern for healthy outcome and positive experience of health care. Women and their families move between the three stages, continuously and reflexively interpreting them, making decisions, and acting on them. As they manoeuvre, they both experience conditions and influence the structural conditions that made action possible. A number of conditions limited health care-seeking, including socio-economic status, family relationships, multiple domestic responsibilities, and uneven power dynamics within health care settings. Following from this, exploring the options involves seeking information and advice, and defining a 'sphere of accessibility'. Health care providers are purposively selected through a phase in which families define their needs and expectations from health care, and examine available evidence on a range of factors, including quality and affordability of health services, provider practices and performance, and health infrastructure and equipment. Assessing provider suitability enables the selection of accessible, appropriate providers. Managing the health care encounter involves using knowledge to interpret experiences with providers and to move within the health care system. This produces various actions that comply with (e.g. tolerating poor care) or

challenge (questioning medical advice and negotiating medical interventions) the structural conditions of the system.

As a form of reflexive monitoring, manoeuvring illustrates some of the ways women understand and internalise the constraints to, and opportunities for, maternity care, as well as how they move through the care-seeking process as individual and collective agents, seeking ways to confront or overcome structural constraints. The chapter provides examples of reflexive monitoring throughout women's maternal health-seeking practices. These included understanding their health condition and the perceived need for routine and curative care, internalising their socio-economic position and its relation to constraint and opportunity, dealing with multiple roles and responsibilities, and their relationships with family members, making health seeking choices, and in their experiences at health care institutions. The latter included the impact of distance and time on other aspects of their lives, quality issues such as the efficiency of services and effectiveness of treatment, costs and benefits of care, and the behaviour of health care staff. Reflexive monitoring produced action. For example, poor experiences of care were interpreted in terms of the structural context of the health care setting and in the woman's ability to influence it or to mobilise resources for future avoidance. The success or failure of this action influenced subsequent actions. Unsuccessful attempts led to adaptive strategies such as accepting one's situation or abandoning care. These had the effect of perpetuating the structured, hierarchical relationship with providers. Successful attempts that involved using agency and mobilising other resources (e.g. social support) included being assertive in the health care encounter, seeking a second opinion, or switching to a superior level of care.

## Chapter 9 Discussion

This chapter revisits the study aims, summarises the main findings, and discusses them in light of existing research, with a focus on urban contexts in low- and middle-income countries. I begin by restating the main determinants of maternity care uptake and choice of provider by women living in Mumbai's informal settlements. I then compare the theory of manoeuvring with the health behaviour models described in the introduction and recent empirical studies on health care-seeking in low- and middle-income countries. I make a parallel between manoeuvring and the reflexive monitoring described in Giddens' structuration theory. This leads to a discussion of implications for current knowledge and future directions for research. I end the chapter by reflecting on some of the methodological issues that arose during the research, its strengths and limitations, and recommendations for future work.

The purpose of the study was to examine patterns of maternal health care-seeking in Mumbai's urban informal settlements and to conceptualise key processes in decision-making and utilisation. I used a mixed-methods approach to (1) quantify patterns of uptake of maternity care and choice of provider, and (2) develop a qualitative grounded theory, through a sociological lens of practice theory and structuration, to explain them. The quantitative analysis drew on primary data collected in a baseline census of more than 3000 women living in informal settlements in Mumbai's two least developed municipal wards. Qualitative data comprised interviews and focus group discussions with five SNEHA Community Organisers and 75 pregnant women and mothers who had chosen public or private maternity services, home-based care, or no care.

In chapter 4.2, I reviewed a number of existing health behaviour models from social psychology, sociology, and medical anthropology. These identified some of the important determinants of health-seeking behaviour and pathways through which people access and utilise different health services. Although the models have made substantial contributions to understanding health-seeking and utilisation behaviours, I argued that disciplinary biases, a general failure to integrate concepts from various fields, and a lack of grounding in empirical data somewhat limit their usefulness and scope. In addition, most explanatory frameworks overlook the impact of broader

social, political, and economic conditions, the complex structural organisation of health systems, and their interaction with individual agency. As a result, most models remain somewhat fragmented and incomplete.

There were several limitations. The quantitative sample relied mainly on participants' retrospective accounts of their health care decisions and behaviour. At least two potential weaknesses result from this. Firstly, there was potential for recall and social desirability bias. There is no reason to suspect that women intentionally gave false information, and the reported patterns of uptake were comparable to government census data on Mumbai's informal settlements (International Institute for Population Sciences and Macro International, 2008). A second limitation of the retrospective design is that it was not possible to observe how women's decisions and behaviour evolved over time. These might have changed throughout pregnancy as they experienced health care. A better approach might involve a longitudinal design with a cohort of participants interviewed more than once at different times during pregnancy and after delivery.

Because of my limited knowledge of Hindi, I was unable to conduct interviews myself. The two junior researchers were fluent in Hindi and Marathi, but were relatively inexperienced and had no knowledge of grounded theory methods. The quality of some of the qualitative interviews varied (see Appendices K and L for examples). Some yielded insufficient data to identify many new concepts or develop existing ones. I met daily with the research assistants to discuss the content and conduct of interviews, through which subsequent interviews improved as the researchers gained knowledge and confidence. The quality of data collection was influenced by participants' unfamiliarity with the research team and constraints on their time. Women were not always willing or able to articulate their experiences and reasons for their health care decisions. This sometimes made it difficult to hold lengthy, in-depth discussions. In focus groups, some younger participants were reticent to speak openly in front of more experienced women.

Time constraints and my limited knowledge of Hindi meant that I did not visit the field as often as I wanted, especially during the later phases of the research when the emerging theory would have benefitted from revisiting participants to refine and

develop emerging conceptual categories. It is possible that the set of concepts that I and my colleagues assigned might not have accurately represented the study participants' meaning. For example, when women complained about being ignored in health facilities they might not have been adequately represented by our conceptual term, "inattentiveness". Qualitative researchers themselves are at risk of selectively reporting their findings (Quinn Patton, 1999).

Other important limitations arose from the fact this was my first encounter with grounded theory. Learning and applying the grounded theory methodology was a challenge. Without a relevant background in positivist social science, the learning curve was steep; there are many potential pitfalls in undertaking a grounded theory study for the first time. In fact, some authors warn against it unless an experienced grounded theorist is on hand to mentor the novice. Thinking conceptually did not come naturally. I was constantly aware of a qualitative tension between describing research participants' lived reality in detail through their own 'voices', and the development of a more abstract understanding through a conceptual lens.

## **9.1 Patterns and determinants of maternity care**

The results of the quantitative analysis showed that a high proportion of women sought institutional maternity care: 94% who had given birth in the two years prior to interview had had at least three prenatal consultations and 85% had delivered in a health facility. However, there were inequalities in patterns of uptake and utilisation across socio-economic groups. Women who were poorer, less educated, or had recently migrated to Mumbai were less likely to have institutional prenatal and delivery care than other women. About two-thirds sought health care in the public sector. Tertiary public hospitals were a common source of maternity care across all groups, while the use of smaller public facilities was relatively low overall. Wealthier, more educated women, as well as Muslim women, were more likely to use the private sector.

The high uptake of prenatal and delivery care is consistent with the findings of previous research conducted with colleagues in Mumbai (Shah More et al., 2009a). The study, covering 48 informal settlements in six municipal wards (including M

East, but not L ward), found that 93% of women who had given birth within two years prior to interview had made three or more prenatal visits and 90% had delivered in a health facility. These rates are higher than those reported in studies from Delhi slums (Agarwal et al., 2007, Devasenapathy et al., 2014, Ghosh-Jerath et al., 2015) and DHS data for urban India as a whole (International Institute for Population Sciences and Macro International, 2007). Other studies of informal settlements in neighbouring south Asian countries have reported high institutional prenatal care rates; for example, 76% in Islamabad, Pakistan (Alam et al., 2004) and 64% in Dhaka, Bangladesh (Kabir and Khan, 2013).

Given that maternity care-seeking among India's urban poor lags behind that among the non-poor (Prakash and Kumar, 2013), the high proportions reported in Mumbai's informal settlements is striking. Ease of physical access to health care is an important factor. In almost all countries, health services and personnel are concentrated in urban areas (World Health Organization, 2006). In India, almost 70% of hospitals and 80% of hospital beds are in cities (Duggal and Gangolli, 2005). As one of India's largest and most metropolitan cities, Mumbai benefits from an extensive health care system that includes health facilities managed by state and central government, and private providers (Brihan Mumbai Corporation, 2009). Maharashtra state also benefits from relatively higher economic development, educational standards, industrialisation, and private-sector growth (Thind et al., 2008). The high uptake of care might reflect a combination of availability, demand linked to access to information about health issues, and more favourable socio-economic conditions, even among Mumbai's poor (Raman et al., 2014, Shah More et al., 2009a).

The public sector was the most common source of maternity care: two-thirds of women who made three or more visits used public sector services and a similar proportion (64%) used public facilities for delivery. In our previous study across other informal settlements (Shah More et al., 2009a), 50% of women who sought prenatal care and 61% of those who delivered in a health facility used the public sector. The differences might be partly explained by variation in socio-economic conditions between areas. The two municipal wards included in this research (M East and L) rank lowest on the UN Human Development Index for Mumbai (Municipal Corporation of Greater Mumbai, 2010). Women living in poorer communities are



likely to depend more on public sector services. The previous study showed that wealthier women tended to seek prenatal care with individual private practitioners but, since these do not provide childbirth services and costs of delivery care in private clinics are relatively high, most switched to a large public hospital for their birth.

Other research suggests that women living in informal settlements in India seek more maternity care in the public sector than the national urban average. Agarwal et al. (2007) reported that, of 100 women interviewed in one Delhi slum, 59% had prenatal care at government hospitals and 17% at a peripheral health post. They did not report why women did not use private providers. Devasenapathy et al. (2014) found that 88% of women in three Delhi slums delivered at public hospitals. Data from the NFHS-4 for urban India as a whole show that 52% of institutional deliveries took place in the public sector and only 26% in the private sector (International Institute for Population Sciences and ICF, 2017). This contrasted with the previous census which showed the reverse trend: 42% of deliveries in the public sector and 56% at private facilities (International Institute for Population Sciences and Macro International, 2007). The recent NFHS-4 data are comparable to findings from a study of Nairobi's informal settlements, where 45% of women gave birth at private health facilities and 21% at government hospitals (Bazant et al., 2009). According to the authors, the reasons for this pattern were the limited availability of government services in informal settlements and higher costs. Private facilities were quicker and easier to reach, and, since a nurse usually attended births, more affordable.

At health facility level, there was a clear preference for large public hospitals over smaller facilities. Between one-third and almost two-thirds of women chose to have their prenatal or delivery care at a tertiary public hospital. Fewer women in our previous study (Shah More et al., 2009a) chose tertiary public hospitals for prenatal care (about one-third), mainly because of the higher use of the private sector. The proportion of institutional deliveries in tertiary hospitals was similar in both studies. Large hospitals are often attractive because they provide integrated and comprehensive services, have modern equipment and technology, and employ specialised staff and expert consultants. These features can lead people to trust in the capacity of providers to treat complications, which can be an important reason for

choosing specific facilities (Russell, 2005). A preference for large hospitals can, however, contribute to overcrowding, longer waiting times, and shorter consultation times. For service users and their families, these can be inconvenient and result in loss of wages, which can in turn dissuade some people from using public sector health facilities (Shah More et al., 2011).

Despite high overall levels of institutional maternity care, patterns of uptake and utilisation vary across socio-economic groups. In this study, the variables that were most significantly associated with uptake of prenatal and delivery care were household economic status, maternal education, parity, and duration of residency in Mumbai. In the adjusted multivariable regression model, household wealth quintile was the strongest predictor of uptake. With each step to a higher quintile, women were 66% more likely to make three or more prenatal visits and 62% more likely to give birth in a health facility. Research has shown a clear link between household wealth and access to health care, especially in countries with a prominent private sector. In a systematic review of factors affecting the utilisation of prenatal care in low- and middle-income countries, 21 studies reported associations between economic factors such as employment and household income, costs of services, transportation, and costs of laboratory tests, and utilisation (Simkhada et al., 2008). Others have reported similar associations between economic circumstances and uptake of professional delivery care (Houweling et al., 2007, Say and Raine, 2007).

Maternal education had a small but significant effect on uptake of prenatal care (aOR: 1.08, 95% CI: 1.04, 1.13) and delivery care (1.07, 95% CI: 1.04, 1.10). Several studies support this finding. Devasenapathy et al. (2014) found that low literacy in slum households in Delhi was a strong predictor of home births. Similar results were reported for prenatal care (Ghosh-Jerath et al., 2015), as in studies of women living in slum areas of Islamabad (Alam et al., 2004) and Dhaka (Kabir and Khan, 2013). Studies in non-slum areas also report associations. Exavery et al. found that Tanzanian women who had studied at primary and higher levels had a 17% higher rate of institutional delivery care than uneducated women (Exavery et al., 2014). In Nairobi, Kenya, Rossier et al. (2014) found that women with little or no education were less likely to receive prenatal care and deliver in a health facility. In Ouagadougou, Burkina Faso, women with primary or secondary schooling were one-

and-a-half times more likely to make at least four prenatal care visits than uneducated women, and those with secondary education were three times as likely to deliver in a health facility (Rossier et al., 2014). In Ethiopia, Hailu and colleagues (Hailu and Berhe, 2014) found that women with formal education were about five times more likely to deliver in a health facility than those without.

Different categorisations of schooling and education across studies, and the failure to disaggregate educational levels, make it difficult to compare results and, therefore, to fully understand the effect of these variables on health care utilisation. However, maternal education can influence health care-seeking in a number of ways. It improves knowledge of health issues and awareness of health services, and might facilitate women's ability to influence household dynamics and health decisions (Prakash and Kumar, 2013, Yadav and Kesarwani, 2015). Educated women often have a greater awareness of risks associated with maternity and the need for preventive health care (Bazant et al., 2009).

Muslim women were about half as likely to seek prenatal and delivery care in the public sector as women of other faiths. Those who did preferred tertiary facilities. Given that the Muslim community in urban India tends to be relatively disadvantaged in comparison with those from non-Muslim faiths (Basant, 2007), it might be expected that they opt for less expensive, subsidised public sector care. The reasons why many chose not to are not immediately clear. Methodologically, it is possible that the higher proportion of Muslim women included in the survey (80%) influenced the results. Religion was not associated with uptake and there were no apparent differences in women's perceptions of the need for care. Although one study in India reported lower rates of prenatal care among Muslims (Yadav and Kesarwani, 2015), others have shown that Muslim women are more likely to deliver in a health facility (Thind et al., 2008).

A fear of low quality care or particular medical procedures may have contributed to a general aversion to public sector services. Most women had a poor opinion of municipal health facilities and some had experienced mistreatment or discrimination from hospital staff. Many of the Muslim women who participated in the qualitative interviews felt that private practitioners provided better services. Another expressed a

clear preference for private care if she could afford it (see appendix L, lines 509-514). A systematic review of global research on mistreatment of women using childbirth services identified 31 studies in which women reported experiencing harsh or rude language from health providers and 13 studies where they faced stigma or discrimination (Bohren et al., 2015). Although some of the studies reviewed had methodological limitations, these are important barriers to health care and can lead women to avoid certain health facilities. In addition, given that maternity care can involve intimate medical examinations, it is possible that cultural conservatism might motivate some Muslim women to seek providers of the same gender or religion (McLean et al., 2012).

Shorter residency in Mumbai was associated with lower uptake of institutional care. Of women who had migrated from outside Mumbai within the last year, 24% made fewer than three prenatal visits and 39% chose a home birth. Studies among Delhi's urban poor have also reported substantially less institutional prenatal and delivery care among recent than among settled migrants (Devasenapathy et al., 2014, Ghosh-Jerath et al., 2015, Kusuma et al., 2013). Stephenson and Matthews (2004) found similar patterns of prenatal care among migrants and non-migrants in Mumbai, but lower rates of institutional delivery. The presence of family social networks influenced health care use: migrant women with limited knowledge of maternal health services tended not to have prenatal care, while those without close family members delivered in a health facility, but only because they had no-one to assist them at home.

Generalising from the quantitative results requires caution because urban informal settlements are culturally, socially, and economically heterogeneous. Multiple factors determine patterns of uptake and use of maternal health services. However, the results are generally supported by similar studies. Socio-economic and demographic inequalities present significant barriers to accessing good quality maternity care, especially among the most disadvantaged. Therefore, explaining health care choices in urban informal settlements requires an understanding of local socio-economic conditions, the structure and availability of health provision, as well as women's and families' own perceptions and preferences.

## **9.2 Comparison of the theory of manoeuvring with existing models**

In the introductory chapter, I described some of the major behavioural models of health- and health care-seeking from social psychology, sociology, and medical anthropology. In summarising their contributions and limitations, I argued that looking at broader, more fundamental sociological theories such as structuration could help illuminate the process of care-seeking. In this section, I revisit the theory of manoeuvring and review some aspects of it in relation to structuration theory, and particularly the concept of reflexive monitoring. Reflecting on some of the theory's conceptual categories, I also consider its applicability to other urban contexts in low- and middle-income countries.

Maternal health care-seeking was motivated by an awareness of the potential risks of pregnancy and childbirth and a desire for positive health outcomes. The theory showed that anxiety and uncertainty caused many women to carefully consider the range of health care options and to take steps to try and access a suitable provider. This contributed to some women choosing or avoiding certain providers from the outset or, if the perceived threat emerged during health care-seeking, abandoning them. One of the motivations for choosing where to give birth was related to perceptions of maternal risk and the safety of a facility-based delivery. Various studies have indicated that safety is an important factor underlying decisions about where to give birth, usually in a health facility. For example, women residents in Delhi slums recognised the possibility of complications during delivery which might require medical intervention (Sudhinaraset et al., 2016).

Manoeuvring comprised three broad behavioural processes: exploring the options, purposive selection, and managing the health care encounter. Exploring the options involved seeking information and advice about maternity services, and gaining an understanding of access to alternatives, while also considering the social and economic implications of maternal health actions for the household. Families then purposively selected one or more potential provider by defining their health and health care needs and assessing the suitability of available providers. The third phase, managing the health care encounter, described a number of actions and strategies aimed at influencing the experience of health care and ensuring a positive outcome.

Women made sense of health care encounters by reconstructing events and experiences, and used them to inform subsequent health care-seeking decisions and behaviours.

One of the aims of the theory of manoeuvring was to make explicit the process of maternity care-seeking by developing an integrated set of conceptual categories. Manoeuvring explained an underlying process that was present throughout women's maternity care-seeking, and also explained most patterns of health care-seeking. Although manoeuvring might initially be understood as a linear process – exploring the options, selecting a provider, and managing the health care encounter – it is better understood as a process involving 'cycles' of manoeuvring in which women make choices and use health care services, then use their experiences of the process to inform subsequent decisions. Furthermore, the direction of movement often changed and families returned to previous stages as they re-evaluated their situation in the light of ongoing experiences, or when social or economic conditions changed. These evolving experiences and conditions often required rethinking strategies and modifying choices, which, again, influenced subsequent health care-seeking decisions.

The social cognitive models (SCMs) described in the introduction explain health-related behaviour in terms of people's perceptions and beliefs about health and illness, and the subjective expectation that engaging in a behaviour will produce a specific outcome. SCMs identify important variables that may predict the likelihood of a range of health-related behaviours. They seem less useful for explaining some patterns of health care utilisation, such as maternity care, because they ignore local health care circumstances (e.g. pluralism, availability of public and private sector providers) and tend to overlook people's perceptions of them.

The sociological theories of health-seeking described in the introduction included Suchman's (1965) five-stage process of illness experience and care-seeking, Igun's (1979) eleven-stage model, and Andersen's (1995) behavioural model of health care utilisation. These models describe determinants and stages along pathways to care. Suchman identified physical, cognitive, and emotional experiences of symptoms indicative of illness as care-seeking triggers. The individual then seeks support from

his or her social group in order to enter the sick role and to establish appropriate behaviours. Choice of medical care provider is influenced primarily by their knowledge of health care and health system characteristics, such as availability and convenience of services. Once the person becomes a patient, the medical system takes over responsibility for treatment until the person's recovery or rehabilitation, and reintegration when health is restored.

Igun's (1979) eleven-stage model is similar, but extends Suchman's model. The concept of symptom-experience mirrors Suchman's except for the inclusion of a symptomatic 'trigger', which alerts the person to the potential presence of an illness. Having entered the sick role, the person's social group provides support and helps identify suitable sources of care. The model identifies additional sources of treatment including self-care, the efficacy of which are assessed throughout the illness episode. The final stage, as in Suchman's model, is recovery and rehabilitation. In common with these two models, the theory of manoeuvring identifies stages in the care-seeking process. These represent "major transitions involving new decisions about the future course of medical care" (Suchman, 1965: 114). In other words, events and occurrences in each phase of health-seeking inform subsequent decisions and actions. One initial difference is that, unless the woman perceives a complication, health care-seeking does not require the presence of symptoms to trigger action; maternal care-seeking is likely based more on routine behavioural influences.

Andersen's (1995) behavioural model organises aspects of cognitive, structural, and social determinants around a series of processes that explain health service utilisation. Within a broad environmental and health care context, predisposing factors, enabling resources, and perceived and evaluated need establish the conditions in which people make decisions about their health care. The model incorporates individuals' experiences with health services, and perceived and evaluated understandings of their health status, which feed back into, and influence, subsequent conditions and behaviours. As stated above, an important feature of health care-seeking models is that people often draw on their previous experiences when making subsequent health care decisions, which can then become habitual. For example, if women perceive that the benefits of seeking care with a particular provider outweigh the alternatives, they are likely to continue with the existing form

of care. However, this cycle is not fixed and can vary if the conditions for health-seeking change and the individual gains access to the necessary social, economic, and cultural resources.

The theory of manoeuvring conceptualises maternity care-seeking as a series of cycles of decisions and behaviours over time. It also shows how women who have advanced along the care-seeking process can return to previous stages, in the event of emerging experiences and circumstances. This addresses a weakness of pathways models that treat health care-seeking as unique or one-directional and overlook the dynamic nature of many health behaviours. As Mackian (2004) says, understanding health care-seeking requires an examination of “the dynamics of engaging in a complex and ongoing process that cannot adequately be conceptualized by measuring dislocated actions aimed at a specific end point” (p. 141). An advantage of the ‘social practice’ perspective used in the development of manoeuvring is that, rather than understanding maternal health care-seeking as an individual behaviour, analysing it as a social practice overcomes the problematic relationship between structure and agency, and which one has a dominating effect over the other.

Social and economic barriers that constrained care for the families in the study were real, and perceptions of access to different types of health provider partly defined in terms of a class consciousness and a broad perception of social and economic disadvantage. The association between status and “helplessness” (*majboori*) corresponds to Varma’s (2004) interpretation of *aukaad*, in which lower status people face barriers to moving beyond assigned limitations. However, manoeuvring showed how women’s health practices were not totally constrained by their socio-economic conditions or cultural meaning: some women challenged or rejected the medical advice of their health care provider and took alternative action. In this sense, health knowledge and health care are subjective, flexible, and negotiable. Information and advice from others were not automatically accepted. By negotiating the medical intervention, families sought to maintain some control over the health care encounter by, for example, questioning clinical diagnoses and recommendations, and seeking a second opinion.



Elements from each of the models described above are contained in the theory of manoeuvring. Pathways models best reflect the theory's emphasis on process. Andersen's comprehensive behavioural model is probably most similar because of its incorporation of feedback of experiences of health care into subsequent decisions and actions. The final phase of the theory of manoeuvring – reconstructing – is, perhaps, more explicit than the behavioural model in its identification of thematic categories considered in reflection of the health care experience.

In chapter 4, I argued for a return to more fundamental sociological theories of practice to help understand the process of care-seeking in complex settings like Mumbai. I discussed Bourdieu's concept of the *Habitus* and Giddens' structuration theory, in particular the process of reflexive monitoring that conjures both structures and agents. Structuration theory and reflexive monitoring are theoretical constructs in what C. Wright Mills described as 'grand theory' (Mills, 2000). They are highly abstract and capable of explaining social processes far broader than health care-seeking. Sociological models such as the pathways models developed by Suchman (Suchman, 1965) and Igun (Igun, 1979) are middle range theories that describe a linear process of health care utilisation. Likewise, Andersen's integrated determinants model is middle-range. The theory of manoeuvring is an empirically grounded theory of a substantive area (Corbin and Strauss, 2008). That is, it seeks to explain a particular social practice in a defined context. In this section, I link manoeuvring to grand theory and argue that it is a form of reflexive monitoring.

Giddens sees structures and agents as mutually constituted, so that when agents engage in social activities they reproduce or reshape systems and structures that make these activities possible (Giddens, 1984). He defines the mechanism through which this happens as the 'reflexive monitoring of action'. Reflexive monitoring refers to the capacity of agents to continuously monitor and interpret their own and others' actions, and the context in which they take place, and to modify them. The modified behaviours lead to both intended and unintended consequences, in terms of the reproduction of social structure or their transformation (Giddens, 1984). To a certain extent, the degree to which social structure constrains health care-seeking depends on the ease or difficulty with which it can be challenged, including access to 'resources' within the structure. Manoeuvring most closely resembles Giddens'

reflexive monitoring of action and performs a similar function: it enables agents to move in the social world in line with prevalent norms, generates an awareness of their capabilities to do certain things within a system, and also challenges or reproduces parts of the system. Several sections of the chapter on manoeuvring illustrated how reflexive monitoring operated in the context of maternity care-seeking. For example, whereas interactions in which women challenged medical advice or sought a second opinion fundamentally changed the dynamic between themselves and providers, and also potentially the actions of women to whom they would provide advice in the future, when women limited their care-seeking because of the constraining effect of poverty or *aukaad*, social norms that perpetuated inequitable access were reproduced. Alternatively, using agency to negotiate quality or outcomes with a provider fundamentally challenged and changed the structure of the encounter. Although individually, these may have operated on a short-term, micro-level, collectively and cumulatively, they have the potential to produce longer-term change, for example, when women share their ‘successful’ encounters and actions with other members of their social network.

Women from low social status backgrounds complained about poor quality care, mistreatment, and discriminatory attitudes of health facility staff, especially in the public sector. Mistreatment during maternity care is common and occurs at various levels of encounter with health systems (Bohren et al., 2015). In a systematic review, Mannava et al. (2015) reported a range of organisational and individual factors that influenced the attitudes and behaviours of maternal health care providers towards service users in low- and middle-income countries. Many of these reflected the experiences of some of the women I describe in this study. It is evident that unfavourable structural and negative cultural conditions not only constrain choices but also make socially and economically deprived groups more susceptible to discrimination and mistreatment by health providers. According to practice theory, this is be one way in which social structure might be instantiated in the health care setting (Giddens, 1984, Maller, 2015). Furthermore, it influences both the nature and experience of action and interaction between provider and client, and has implications for the reproduction of maternity care practices. Poor experiences result in dissatisfaction with services, fear and mistrust of providers, and can lead to underutilisation or rejection of institutional maternity care. Qualitative research,

especially using ethnographic methods, in private and public health facilities, could provide insights into the socio-cultural dynamics and interaction between service providers and users, and the motivations and characteristics underlying patient mistreatment in India. These insights could contribute to the design of integrated health system strengthening and community-based interventions to reduce misunderstanding and discrimination, improve the quality of services, and enhance client experience.

Manoeuvring shows how structures are not completely rigid. Rather, agents interpret the structures and actions they interact with, and have the potential to challenge them. For example, according to the ‘constrained choices’ model developed by Bird and Rieker (2008, 2010), an uneducated woman from a poor socio-economic background would be likely to have a home birth or be compelled to utilise subsidized public sector health care. However, by drawing on structuration theory, manoeuvring demonstrated the possibility that under certain conditions (for example, if the woman perceived the quality of public sector care to be too low or feared undergoing caesarean section), agents can draw on resources such as knowledge and skills to take alternative actions or use particular strategies (e.g. take a loan) to access a private sector provider. Therefore, in ‘extreme’ circumstances (e.g. fear of caesarean section), normal structural rules can be challenged and successfully confronted.

### **9.3 Comparison of the theory with health care-seeking literature**

In this section, I compare some relevant empirical studies with the theory of manoeuvring in order to consider its applicability to maternal health care-seeking in other urban contexts in low- and middle-income settings. Descriptive studies tend to focus on the effects of individual determinants on uptake and place of delivery. Few explore the conditions and processes through which these factors operate. In the theory of manoeuvring, I sought to emphasise the key processes and how they were influenced by socio-economic conditions, perceptions of providers, and experiences of care.

The qualitative analysis revealed a common concern among participants about the quality and outcomes of institutional maternity care. Their concerns are well founded. Media reports and academic studies have brought to light the scale and nature of deficiencies in health care quality in low- and middle-income countries (Berendes et al., 2011, Contractor, 2009, Khan, 2015). Common issues include inadequate public sector infrastructure (Dilip and Duggal, 2004, Municipal Corporation of Greater Mumbai, 2010), inappropriate medical practices, poor technical competence, low provider effort (Das et al., 2008, Radwan, 2005), discrimination against low socio-economic groups (Rani et al., 2008, Sudhinaraset et al., 2016), and disrespect and abuse of women during childbirth (Bohren et al., 2015, Freedman and Kruk, 2014, World Health Organization, 2015).

Studies highlight a range of themes related to health care seeking, often in terms of barriers and facilitators to access. Knowledge and awareness of maternal health and illness have been shown to influence uptake of services (Bohren et al., 2014). In studies from Ethiopia, India, and Kenya, perceptions of risk and the causes and severity of complications figured prominently as motivations to seek care (Izugbara et al., 2009, Sudhinaraset et al., 2016, Warren, 2010). In the event of a complication, delivering in a health facility was considered beneficial because of the safety of having access to skilled providers and equipment. Interestingly, women in Nairobi's informal settlements considered failing to have formal prenatal care more risky than home delivery (Izugbara et al., 2009). This contradicts the argument that prenatal care increases the likelihood of institutional delivery; although women recognised the importance of hospital care for complication, in cases where a normal delivery was indicated, a home birth was expected.

The sociological and ethnographic literature on rural and urban India describes a context of increasing institutional delivery in a predominantly biomedical system of health care. It indicates that traditional ideas of pregnancy and childbirth as natural processes in which women prefer to deliver at home with family support and in the presence of a *dai* are increasingly being replaced by a biomedical perspective, whereby childbirth is constructed as a potentially risky medical event that requires monitoring and management in a hospital environment. These changes need to be understood against a backdrop of dominant biomedical models of health care as well

as historical national and international campaigns that prioritise the interests of the state over women (Naraindas, 2009). In their examination of local interpretations of NRHM activities, Mishra and Roalkvan (2014) argue that, rather than functioning as a rights-based programme that empowers women to act, NRHM mostly helped the state ensure compliance in terms of achieving higher rates of institutional childbirth. In contradiction to their objectives, NRHM activities (through ASHAs, outreach activities, and cash incentives) appear to reproduce the idea of the state as protector and subordinate citizens as recipients. Perinatal health choices in the poor urban setting are influenced by rational ideas about the ability of families to provide for children in conditions where space is constrained and cost of living higher than in rural areas (Raman et al., 2014).

Dimensions of accessibility can act as barriers to health care. Financial difficulties related to the direct and indirect costs of health care mean that many women find seeking health care unaffordable (Izugbara et al., 2009, Sudhinaraset et al., 2016). For the poorest, health care is expensive, even in public sector facilities where costs were low. Sudhinaraset et al. (2016) found that accessibility influenced choice of health care provider in India. Most women felt that public facilities had longer waiting times, paid little attention to the quality of interpersonal interactions between staff and patients, and lacked equipment. Although the private sector was considered better because of the need to pay for care, access naturally depended on families' financial capacity. Quantitative analyses in urban settings have consistently shown an association between household economic status and the use of health care (Bazant et al., 2009, Prakash and Kumar, 2013, Rossier et al., 2014). In some studies, poor quality was mentioned as a barrier to care-seeking. Sudhinaraset (2016), for example, reported that women's perceptions of the quality of interaction with health care staff in Lucknow slums influenced their decisions about whether to deliver in a health facility as well as their choice of health sector. Although Devasenapathy et al. (2014) found that none of the participants in their study in Delhi slums cited poor quality as a reason to deliver at home, the authors observed the need for improvement.

Access to health care in rural and urban India is inequitable. My qualitative theory described how low status Muslim women were particularly deterred from seeking maternity care in the public sector because of a fear of mistreatment or poor health

outcomes. Although they expressed a preference for private sector care, the relatively high costs prevented some from gaining access. There is a clear tension between the desires of poor or otherwise marginalised women to access and negotiate good quality services and the provision of respectful care. In India, this is an ideological failure of neoliberal policies that view people as equally capable of navigating the health care market. Although government health programmes have increased rates of institutional delivery in India, the quality of care provided urgently requires further improvement (Jha et al., 2016). Complaints about poor medical and social quality of care in rural and urban India remain common, especially in government health facilities. Until this is addressed, resistance to perinatal health policy initiatives is likely to continue (Jeffery and Jeffery, 2010a).

Low status women exercise limited agency over their own health and frequently experience various forms of systemic violence in the health system, especially in government health facilities. The combination of a biomedical emphasis on perinatal interventions and discriminatory attitudes and behaviours based on class, caste, and religion has a detrimental effect on women's and their families' experiences of pregnancy and health care. Structural violence limits individuals' opportunities and capabilities, partly explaining why the poorest experience worse health and wellbeing (Napier et al., 2014). As Chattopadhyay (2018) affirms, the combination of gender, class, caste, and religious inequities disempowers women and leaves them without the social, economic, and cultural capital to exercise the agency to enable them to counter mistreatment and disrespect in health care encounters. As a result, the best that some women can expect is 'safe, yet violent' care (Chattopadhyay et al., 2018).

A few studies have reported the influence of prior health care experiences on subsequent decisions (Devasenapathy et al., 2014, Sudhinaraset et al., 2016). These can be women's own experiences or those of friends and relatives. Decisions are influenced by the attitudes and experiences of family and friends, who are themselves influenced by social and economic conditions. Intra-household dynamics and the relationships between family members also influence maternal health-seeking (Sudhinaraset et al., 2016). Husbands and in-laws are dominant decision-makers in perinatal health care. Decisions are often imposed from within a structured

family hierarchy, but the views and preferences of pregnant women are taken into account to a greater or lesser degree. Women who lack experience or are new to the area often seek recommendations from other women or neighbours prior to making decisions about whether and where to seek institutional maternity care (Gawde et al., 2016). Devasenapathy et al. (2014) reported that women in Delhi slums considered a negative personal experience with a health care provider an important reason to have the following birth at home. As an element of manoeuvring, the findings of these studies suggest that, rather than reject health care altogether, a poor experience sometimes led women to abandon one facility and seek an alternative provider. This behaviour was seemingly driven by the same motivation that led them to choose institutional care in the first place. Neither Sudhinaraset et al. nor Devasenapathy et al. explored these mechanisms.

I found two other studies that used grounded theory methods to conceptualise maternity care-seeking in low- and middle-income settings. They provided an interesting comparison to the theory of manoeuvring and resonated with many of my qualitative findings. Odberg Pettersson et al. (Odberg Pettersson et al., 2004) developed a conceptual model around the core category 'moulding of women's care-seeking behaviour during childbirth' in Luanda, Angola. Moulding described a process through which women had to adapt to changing circumstances and ambivalence, depending on a combination of their perceptions about the progression of their labour and about health care, which compelled them to either avoid (reject) or approach (accept) institutional delivery. Structural, cultural, socio-economic, political, and demographic conditions also influenced the process. Another grounded theory study, which examined Iranian Kurdish pregnant women's choice of childbirth method, had 'safe passage' as a core category (Shahoei et al., 2011). The process involved five categories: safety of baby, fear, previous experience, social support, and faith. The authors say that these categories represent phases in the decision-making process. However, since they give no sense of movement through stages, they appear to represent as important themes that were identified in participant interviews. Although most women expressed a preference for a natural, vaginal birth, the method itself was given less emphasis than protecting the baby from harm. The study showed how emotions have an important influence on decisions about childbirth. Women considered themselves responsible for the safety

of their unborn baby and were seemingly aware of the impact their decisions and actions had on the baby's health.

Although the specific health decisions and behaviours differed, moulding and manoeuvring both involved responses to internal and external conditions and the ability with which women were able to control them. Manoeuvring explained a process through which families responded to their concerns for positive experiences and outcomes of health care within constraining socio-economic conditions. As Warren (2010) notes, the sense is that many decisions and behaviours related to maternal care-seeking involve “a balance between retaining control of the process and outcome, and securing a safe delivery” (p. 103).

Focusing on suitability as a means of selecting health providers contrasts with the type of prescribed care-seeking one might expect in high-income countries where, based on a common understanding of the competency and motivations of medical staff, the existence and efficacy of regulation etc., a certain level of care is to be expected, which may be confirmed or disproved through experience. In urban India, since levels of care and outcomes are sometimes uncertain, initiation of care-seeking might involve seeking available information and evidence about specific providers first, then examining the evidence in order to draw conclusions about quality and likely outcomes prior to making a decision.

#### **9.4 Contribution of the study**

The study contributes to existing knowledge and models of health-seeking behaviour through an understanding of how families in underserved urban communities with inequitable access to health services choose, engage with, and experience health care. This important aspect of health service utilisation has received limited attention.

The thesis makes two salient contributions. First, it is an attempt at producing an empirical, triangulated qualitative and quantitative examination of patterns of maternity care-seeking in informal urban settlements in Mumbai. As such, it provides a more comprehensive account of the dynamic care-seeking process than studies employing single methods. Second, the study presents a summative theory of maternity care-seeking that (a) moves beyond purely descriptive accounts of the



barriers and facilitators to health care and surpasses existing models in its inclusiveness and grounded nature, and (b) may be useful to predict patterns of maternity-related care-seeking in other medically pluralistic urban environments in the global south. The latter contribution is important given current global projections for urban growth and the urbanisation (and feminisation) of poverty. Furthermore, the precarious conditions and urban penalty in which many of the urban poor find themselves demands more intensive efforts towards understanding and predicting health care-seeking choices in informal urban settlements; choices which will be crucial to addressing inequalities.

## **9.5 Strengths and limitations**

A major strength of the thesis was the use of a large primary quantitative dataset with disaggregated data on patterns of health care utilisation in both public and private sectors. The SNEHA Centre trial was implemented in 40 clusters over a total of five years, employed a substantial number of field staff, and required an extensive surveillance system. An additional benefit of having a prominent presence in the community was that it facilitated access to residents through the rapport that field teams had built with community members.

A further strength was the ability to identify individual participants from the dataset based on their socio-economic characteristics and health care choices. This allowed me to conduct qualitative interviews around key themes that emerged from the quantitative analysis. Using a mixed methods approach that combined the quantification of patterns and determinants of health care utilisation and a grounded theory based on qualitative data led to a more comprehensive analysis of care-seeking.

## Chapter 10 Conclusions

Despite substantial global reductions in maternal and perinatal mortality over the past two decades, making motherhood safer in low- and middle-income countries remains a global priority. India lags behind many other Asian countries and still has more maternal deaths than anywhere else in the world. Given the current trend in urban growth and the urbanisation of poverty, the pressure to meet the health needs of the urban poor has, perhaps, never been greater. Improving access to health care is crucial to addressing population health needs, but understanding patterns and pathways to health care is also necessary to develop appropriate interventions and know where and how to implement them effectively. The aim of this thesis was to examine maternal health care-seeking in informal settlements in two of the poorest municipal wards in Mumbai. Using a mixed methods approach, I quantified patterns of uptake and choice of maternity care provider and explained the care-seeking process using grounded theory methods.

Most women in the study had secondary-level education, although one-third had little or no schooling. More than half were long-term residents of Mumbai (ten or more years) and were of the Muslim faith. Uptake of maternity care was high across all socio-economic levels. The public sector was the commonest source of prenatal and delivery care, especially in larger, reputable hospitals that provided comprehensive care. However, most women preferred the private sector because of superior services and a more satisfactory experience. Uptake and access to private health care were inequitable and associated with higher economic status, education, residency, and lower parity. Muslim women were more likely than Hindus to seek private sector care.

For families living in Mumbai's informal urban settlements, the process of choosing and utilising health care is complex. Difficult social and economic conditions constrain opportunities to seek maternity care and create inequities in access and utilisation. Demand for services is high, however, and driven by perceived benefits of health care and a focus on positive maternity outcomes. At the same time, concerned for poor experiences and outcomes of care, women are compelled to seek information and advice from their social groups, assess provider practices and

behaviour, selectively choose providers, and reflect on their own and others' experiences of health care. Women reflexively monitor their conditions, experiences, and interactions throughout the process of health care-seeking. Where possible, they take steps to maintain control and exercise agency over the health-seeking process. Within a broader framework of practice theory and structuration, I conceptualised these various interrelated stages as manoeuvring.

The cultural significance of childbearing and an understanding of the potential risks of pregnancy and childbirth provide the motivation for many women to seek professional prenatal and delivery care. The availability and diversity of health care options in cities such as Mumbai provide better access to health facilities and increase choice for people across socio-economic levels. The high uptake of maternity services in urban India is encouraging. It indicates that institutional care among the urban poor is the norm. Rates are higher than national and state averages and continue to improve. This suggests that there is a demand for services – families perceive a need for health care and are able to access it. The public sector covers a substantial proportion of the population it is intended to serve. Despite underfunding, inadequate infrastructure and human resources, and suboptimal standards of care, the health system in Mumbai is extensive and functional. It includes a substantial private sector and a public sector that provides affordable services through a hierarchy of health facilities, from primary health posts in community settings, secondary hospitals with inpatient services, to a few multi-speciality tertiary hospitals. In theory, any resident who requires health care can visit a local general practitioner or municipal health post and, if required, be referred to a hospital for more specialised care.

However, patterns of uptake and choice of provider are diverse and complex. The urban advantage previously associated with city residence is becoming – at least for the poorest – an urban penalty. Widespread inequalities across social, economic, and cultural domains present significant barriers to access and limit choice. Most people want to use the best services available, but the opportunities for them to do so are often limited by unjust socio-economic conditions. Not only does this jeopardise their physical wellbeing, but it also causes psychological distress, such as anxiety and uncertainty, for those who need or wish to use health care. It also has a

detrimental effect on the experience of maternity and maternal health care. This shifts the emphasis of the research agenda from only physical access, uptake, and health outcomes to understanding people's choice of provider and their experience of services.

From a critical perspective, manoeuvring might be understood as a response to unfavourable political, social and economic conditions prevalent in low-income urban settings. It is a series of behaviours necessarily used by poorer families seeking health care that is accessible, affordable, acceptable and safe. In a medically-pluralistic setting, with an underfunded public health system and poorly regulated private sector, people are often unsure about standards and outcomes of health care utilisation. As a result, they feel compelled to find out about care options, mobilise resources, and take specific actions to avoid poor care. Part of the explanation may also lie in lay narratives of risk and negativity towards the public sector. In line with aspirations to modernity, people aspire to good quality health care, which they are more likely to find in the private sector.

As a substantive theory, 'manoeuvring' appears a useful concept to explain the overall process of maternal health care-seeking. Beyond describing the way women and their families navigate opportunities and obstacles, it conceptualises the process in terms of cycles of manoeuvring, in which women try to understand the health care context, make careful choices about where and with whom to consult, try to improve their access, and manage their encounters with providers. The theory frames the process in a way that recognises the complex, dynamic nature of care-seeking behaviour. It would benefit from further development and testing by applying its major concepts in other substantive areas of health care-seeking.

## Chapter 11 Recommendations

The recommendations that emerge from the study centre on the need to address inequalities in access to public and private maternity services, oversee more closely the behaviour and practices of the health sector, and improve the health care experiences of the urban poor.

Future health policies will benefit from a greater understanding of how vulnerable urban populations make health care decisions and interact with health services in a context of inequality and uncertainty. Studies such as this one make an important contribution, but are scarce. Further research in informal urban settlements, preferably using mixed methods designs, will provide valuable, comprehensive insights that can be used to inform health policy. There is an urgent need for research on the role and behaviour of the private sector in the provision of health services in poor neighbourhoods. Specifically, there is a need for detailed research that focuses on “what ensues inside these clinics, what the practitioners do on a daily basis and the exact motivations that drive the practitioners to perform during interactions with patients” (Barua, 2005: 7). Research both at the facility and in the community would help explain why, when, and how people use health services (Mackian et al., 2004).

Provision of clear and up-to-date information about local health care providers and the range of health services they offer would help poor urban residents make more informed choices. Information might include the number and availability of levels of staff, equipment and supplies, facility timings, advice about procedures for accessing services – such as prenatal care – and charges for consultation, investigations, and medicines.

As a crucial provider of health care services to the poor, municipal government must work towards a more equitable provision of health services in terms of availability, functioning, adequacy, and appropriateness of facilities and services in the public health care system. Potential measures might include more equitable distribution of financial incentive schemes such as the *Janani Suraksha Yojana* (JSY), the introduction and monitoring of health insurance for the urban poor, and the strengthening of public-private partnerships (PPP).

Improvements in administrative and organizational processes in public sector health facilities could enhance the experience of the urban poor. These might include: (1) improving admission and consultation procedures to reduce waiting times; (2) training staff on interpersonal skills and nonviolent communication; (3) establishing effective grievance mechanisms that give people the opportunity to report poor care and make service providers more accountable to clients; and (4) a move towards “patient friendly” health care and a more sensitive attitude to patient health care rights.

Finally, it is important to restate the need for systematic implementation of regulatory mechanisms, particularly in the private health care sector, to ensure that practitioners providing services to residents of informal settlements are competent. This should include verification of provider qualifications and continued medical education, adequacy of facilities and equipment, registration with the appropriate medical state-level authority (e.g. the Maharashtra Medical Council) and the appropriateness and quality of health care practices.

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## Appendix A. Published article - Examining inequalities in maternal health care

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### RESEARCH ARTICLE

### Open Access



# Examining inequalities in uptake of maternal health care and choice of provider in underserved urban areas of Mumbai, India: a mixed methods study

Glyn Alcock<sup>1\*</sup>, Sushmita Das<sup>2</sup>, Neena Shah More<sup>2</sup>, Ketaki Hate<sup>2</sup>, Sharda More<sup>2</sup>, Shanti Pantvaidya<sup>2</sup>, David Osrin<sup>1</sup> and Tanja AJ Houweling<sup>1,3</sup>

#### Abstract

**Background:** Discussions of maternity care in developing countries tend to emphasise service uptake and overlook choice of provider. Understanding how families choose among health providers is essential to addressing inequitable access to care. Our objectives were to quantify the determinants and choice of maternity care provider in Mumbai's informal urban settlements, and to explore the reasons underlying their choices.

**Methods:** The study was conducted in informal urban communities in eastern Mumbai. We developed regression models using data from a census of married women aged 15–49 to test for associations between maternal characteristics and uptake of care and choice of provider. We then conducted seven focus group discussions and 16 in-depth interviews with purposively selected participants, and used grounded theory methods to examine the reasons for their choices.

**Results:** Three thousand eight hundred forty-eight women who had given birth in the preceding 2 years were interviewed in the census. The odds of institutional prenatal and delivery care increased with education, economic status, and duration of residence in Mumbai, and decreased with parity. Tertiary public hospitals were the commonest site of care, but there was a preference for private hospitals with increasing socio-economic status. Women were more likely to use tertiary public hospitals for delivery if they had fewer children and were Hindu. The odds of delivery in the private sector increased with maternal education, wealth, age, recent arrival in Mumbai, and Muslim faith. Four processes were identified in choosing a health care provider: exploring the options, defining a sphere of access, negotiating autonomy, and protective reasoning. Women seeking a positive health experience and outcome adopted strategies to select the best or most suitable, accessible provider.

**Conclusions:** In Mumbai's informal settlements, institutional maternity care is the norm, except among recent migrants. Poor perceptions of primary public health facilities often cause residents to bypass them in favour of tertiary hospitals or private sector facilities. Families follow a complex selection process, mediated by their ability to mobilise economic and social resources, and a concern for positive experiences of health care and outcomes. Health managers must ensure quality services, a functioning regulatory mechanism, and monitoring of provider behaviour.

**Keywords:** Maternal health, Health inequalities, Health care utilisation, Determinants of care, Urban slums, India

\* Correspondence: g.alcock@ucl.ac.uk

<sup>1</sup>Institute for Global Health, University College London, 30 Guilford Street, London WC1N 1EH, UK

Full list of author information is available at the end of the article



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## Background

Poor coverage and low uptake of skilled maternity care are major contributors to maternal morbidity and mortality. India alone accounts for 17 % of the 289 000 annual global pregnancy-related deaths [1]. Safe motherhood requires adequate distribution of health services, access to emergency obstetric care, and skilled birth attendance [2].

Individual, household, community, and health system factors affect access to and utilisation of health care. At the individual and household levels, economic status is a key determinant. Analysis of Demographic and Health Survey (DHS) data from 45 developing countries has shown that wealthier women are much more likely than poorer women to have prenatal care and to deliver with a skilled attendant [3]. Other country-level studies support this trend. In Nigeria, women in the highest household wealth quintile are at least seven times more likely to deliver in a health facility than women in the lowest [4]. In Cambodia, the wealthiest women are almost 12 times more likely to do so [5].

Other determinants include maternal age, education, and parity. For example, younger, less educated women from lower socioeconomic groups in Brazil make inadequate use of prenatal care services [6]. In Bangladesh, skilled maternity care among married adolescents is associated with higher education and wealth index, urban residence, and lower birth order [7]. In India, women in northern states and rural areas use maternal health care less than others; barriers include low household economic status, caste, maternal and paternal education, higher birth order, Muslim faith, and less exposure to mass media [8, 9].

Some research suggests that women's autonomy affects maternal care-seeking [10–12]. In Ethiopia, women who were ultimately responsible for decisions about birthplace were almost four times more likely to deliver at a health facility than those who were not [13]. In Tajikistan, women with financial decision-making power were more likely to attend at least one prenatal consultation (although less likely to attend four or more), deliver with a skilled provider, and seek institutional delivery care. However, associations are contextual; autonomy might be a weak predictor of care uptake in general [14], but more strongly associated with choosing private over public sector care [15].

Studies in diverse settings have shown associations between urban location and institutional delivery [5, 7, 16]. Urban residents benefit from a concentration of health infrastructure and proximity of services. However, population growth creates greater demand for health services. When these services are unevenly distributed, access becomes unequal. These inequalities adversely affect disadvantaged groups in underserved neighbourhoods [17]. Our previous research has shown a positive association between higher socioeconomic

status and the use of private prenatal and delivery care by women from informal urban settlements (slums) in Mumbai [18].

India is the world's fastest urbanising country; currently, 410 million Indians (one-third of the total population) live in urban areas. Mumbai, the country's second largest city, has more than 16 million inhabitants [19], more than 40 % of whom live in slum areas [20]. The health care sector is characterised by a co-existence of medical systems and public and private providers. Public sector infrastructure includes teaching hospitals, specialist hospitals, general hospitals, maternity hospitals, and community-level health posts and dispensaries [21]. The private sector includes super-speciality hospitals, medium-sized facilities that provide both outpatient and inpatient care, and a substantial number of smaller practices that offer limited services. Most urban health care across socioeconomic groups, including the disadvantaged, is privately provided. The sector is virtually unregulated and many practitioners are underqualified or lack formal training [22, 23].

Because institutional prenatal and delivery services are often underutilised, discussions of maternity care in low- and middle-income countries have emphasised uptake of services, followed by a consideration of quality. While some research has documented the utilisation of public and private sector services [5, 24, 25], choice of specific types of facility within each sector has largely been ignored. Understanding how families in underserved urban communities choose among health providers is essential. Although the public sector is an important source of health care for the urban poor, private practitioners dominate in many low-income communities. Examining health care-seeking behaviours in these communities is key to developing effective strategies that address inequalities, improve access, and help protect the poor against unaffordable health costs [26].

Our objectives were to quantify the pattern, determinants, and choice of maternity care provider at the health facility level in the public and private sectors in Mumbai's informal urban settlements, and to explore the reasons underlying these choices. We were interested in examining two aspects of choice that have appeared rarely in discussions: private sector maternity care for poor people whose substantial use of it has gone largely unnoticed, and the ways in which they decide which providers they will use. Our broad hypothesis was that the likelihood of institutional prenatal care, delivery, and private health care would all increase as maternal education, duration of residency, and economic status increased.

## Methods

### Study setting

The study was conducted in informal settlements in two eastern municipal wards in Mumbai (M East and L).

Both rank lowest on the UN Human Development Index for the city with a comparatively high concentration of slum residency (78 and 85 % respectively), higher infant mortality, lower life expectancy, and lower female literacy and employment. The majority of residents are of Muslim faith [27]. The two wards were included in a cluster randomised controlled trial of community resource centres. Centres served as a base for the collection and dissemination of health information, home visits, care for malnourished children, referral of individuals and families to appropriate services, meetings of community members and providers, and events and campaigns on health issues [28]. Trial areas comprised 40 informal settlements, each of approximately 600 households, and covered a population of ~120 000.

#### Study design, participants, and tools

We used a sequential mixed-methods design [29]. First, we analysed data from a baseline census to describe determinants of maternity care, then used grounded theory methods to examine women's choice and utilisation of provider. We used this approach in order to (1) describe the quantitative patterns and determinants of maternity care utilisation, (2) from the quantitative results, purposively select individual women from social, economic, and demographic characteristics and choice of health care provider, (3) explore possible relationships between the observed quantitative patterns and determinants of care, and women's narratives of care-seeking, and (4) triangulate quantitative and qualitative data.

The research team comprised a principal investigator (TH), a senior data manager (SD), a senior researcher (DO), an experienced male qualitative researcher (GA), two female junior qualitative researchers (KH and SM), SNEHA's Executive Director of Programs (SP) and the Program Director for the resource centre trial (NSM).

We used two datasets in the study: the trial baseline census for the quantitative analysis and the intervention database to identify participants for qualitative interview. Census respondents were all residents of trial areas and were married women in the 15–49 age group. The actual ages of respondents included in the census ranged from 17–49. The intervention database allowed us to purposively sample individual women based on their care-seeking behaviour and because we did not expect the trial to impact choice of provider. Selection criteria for qualitative interview included married women aged 18 and over who were currently pregnant or had given birth (at home or in a health facility) in the previous two years.

#### Data collection

Quantitative data were collected in a baseline census over 18 months from September 2011 to March 2013. All respondents gave signed consent prior to interview.

Interviewers took household GPS coordinates and enumerated household members, their ages, schooling and livelihoods. The interview covered duration of residence, assets and amenities, housing fabric and faith. Women provided brief maternity histories and information on family planning.

Data were collected on smartphones running Open Data Kit ([www.opendatakit.org](http://www.opendatakit.org)), which included in-built skips and validation constraints. After checks for completeness, data were uploaded to a secure database in ODK Aggregate. They were cleaned and analysed in Stata 12 (StataCorp, College Station, Tx: [www.stata.com](http://www.stata.com)).

We used semi-structured topic guides for qualitative data collection, including sections on the respondent's background (e.g. place of origin, family structure), experiences of pregnancy and childbirth, maternity care, and choice of provider. Women were explained the purpose of the study and assured of confidentiality before giving verbal consent to participate. KH and SM conducted seven focus groups (alternating between moderating and note-taking) with married women (average, eight per group), 16 in-depth interviews, one group discussion with five SNEHA Community Organisers, and an interview with the mother-in-law of two respondents. In total, 78 women from nine clusters participated. Focus groups took place at the nearest nongovernment outreach centre and most interviews in the participant's home. They were conducted in Hindi or Marathi and lasted from 30 min to over an hour. We stopped data collection when we felt concepts and themes were sufficiently developed.

Focus groups and interviews were digitally recorded and transferred to two password-protected computers. The interviewers anonymised and transcribed their own interviews verbatim and translated them into English for dissemination among the research team. Translated transcripts were randomly selected and cross-checked for accuracy.

#### Analysis

##### Quantitative analysis

**Dependent variables** We were interested in examining uptake of prenatal and institutional delivery care, whether it was in the public or private sector, and whether women's choices favoured tertiary public hospitals. We defined prenatal care as attendance for at least three check-ups (the locally recommended minimum). Public sector facilities providing prenatal care included municipal health posts, urban health centres, maternity homes, general hospitals, and tertiary hospitals. We included established, large state government hospitals in the latter group as they provide free or low-cost services. Delivery was possible at all these types of facility except for health posts. Private sector



facilities included single-handed practices without inpatient services, small maternity homes and inpatient centres, and larger hospitals. Delivery was possible at all but single-handed facilities without beds.

**Independent variables** We chose variables purposively from the available dataset, to reflect socio-economic position (household asset index, maternal schooling), demography (maternal age, parity), establishment and familiarity with healthcare options (duration of residence), and socio-cultural milieu (faith). Maternal schooling was described in an ordered categorical variable as none, primary, secondary, or higher than secondary. Socio-economic position was described by quintiles of an asset index developed from standardized weights of the first component of a principal components analysis [30, 31]. Assets included home ownership, possession of a ration card, robust housing fabric, private water supply, private toilet, finished floor, and possession of a mattress, pressure cooker, gas cylinder, stove, bed, table, clock, mixer, telephone, refrigerator, or television. Duration of residence was a continuous variable describing the number of years the woman had been living in Mumbai. A continuous variable describing parity included the index pregnancy in the preceding two years. Faith was categorized as a binary variable describing Muslim or other faith.

**Statistical analysis** The analyses included women who had reported a birth in the 2 years preceding the census. We tabulated frequencies and percentages of attendance for prenatal care, its location in the private or public sector, and the use of tertiary hospitals and smaller public sector institutions, against the chosen independent variables. We did the same for institutional delivery.

For each combination of dependent and independent variables, we developed a univariable logistic regression model with a random effect for cluster. For prenatal care, whether the woman had 3 or more visits (denominator: all women who had had a pregnancy in the preceding 2 years), whether the prenatal care was in the public rather than the private sector (denominator: women who had made more than 3 prenatal care visits), and whether it was in a large public hospital rather than a smaller one (denominator: women who had made more than 3 prenatal visits in the public sector). For delivery, whether institutional or at home (denominator: women had delivered in the preceding 2 years), whether it was in the public rather than the private sector (denominator: women who had had an institutional delivery), and whether it was in a large public hospital rather than a smaller one (denominator: women who had delivered in the public sector).

For each outcome, we created a single multivariable logistic regression model with random effect for cluster. All models included adjustment covariates selected as

markers of socio-economic position, demography, establishment and familiarity with healthcare options, and socio-cultural milieu. Age and parity were both included in the models since the Stata *collin* package did not suggest collinearity. All models satisfied quadrature parameters.

#### Qualitative analysis

We used grounded theory (GT) methods. GT is an inductive research methodology to generate theory through the development of conceptual categories that are *grounded* in systematically collected and analysed data [32, 33]. We coded the English transcripts in NVivo version 10 (QSR International: <http://www.qsrinternational.com>). We began by open coding transcripts individually and analysed them collectively to identify and explore descriptive and higher-level conceptual categories. We tested emerging categories and interpretation through constant comparison and presentations to colleagues.

Ethical approval for the study was granted by the UCL Ethics Committee and the Multi-institutional Ethics Committee of the Anusandhan Trust in Mumbai.

## Results

### Quantitative

Data for the study were provided by 3848 women who had delivered a baby in the preceding two years. Table 1 presents information on these women. Just over half had some secondary education and more than half said that they had lived in Mumbai for at least 10 years. Most (74 %) were in the age group 20–29 years and 56 % had one or two children. Most were Muslim (83 %).

Table 2 summarizes choice of prenatal care provider and Fig. 1 delivery care for all women who had delivered in the preceding two years for the whole sample and by socio-economic and socio-demographic characteristics. Overall, institutional maternity care-seeking was high: 94 % made three or more prenatal visits and 85 % had a facility delivery. Uptake of prenatal care and institutional delivery care was lower for women who never went to school, were poorer, and who had recently arrived in Mumbai. Note that in our sample the wealthiest were simply the least poor quintile group in a vulnerable urban slum population. Uptake of prenatal and delivery care was also lower for older women with more children. Within the public sector, there was a preference for tertiary (municipal or state) hospitals across all socio-economic positions, although this fell with increasing parity. Preference for private hospitals, for both prenatal and delivery care, increased with household economic status. A greater proportion of Muslim women went to private hospitals for prenatal care and delivery (33 and 32 %, respectively) than Hindu women (18 and 21 %, respectively). The longer women had lived in Mumbai,

**Table 1** Characteristics of 3848 women respondents in 40 informal settlement areas in Mumbai who had delivered in the two years preceding the census

	Respondents	(%)
Maternal education		
None or informal	1170	(30)
Primary	236	(6)
Secondary	2144	(56)
Higher	297	(8)
Missing	1	(<1)
Household asset quintile		
Quintile 1	771	(20)
Quintile 2	769	(20)
Quintile 3	785	(20)
Quintile 4	758	(20)
Quintile 5	765	(20)
Duration of residency in Mumbai		
Less than 1 year	260	(7)
1–4 years	867	(22)
5–9 years	561	(15)
10 years or more	2160	(56)
Age		
Under 20	139	(3)
20–29	2841	(74)
30–39	804	(21)
40–49	64	(2)
Parity, including index delivery		
1	1168	(30)
2	1009	(26)
3	765	(20)
4	413	(11)
5 or more	493	(13)
Religion		
Muslim	3184	(83)
Hindu	651	(17)
Other	13	(<1)
All	3848	(100)

the higher the proportion who went to tertiary public hospitals, especially for prenatal care.

Table 3 summarizes the findings of univariable and multi-variable models. The odds of prenatal care increased with education, economic status in terms of household asset quintile, and duration of stay in Mumbai, and decreased with parity. Similar associations were found for institutional delivery. Of those who opted for institutional care, women were more likely to have prenatal care and delivery in the

private than the public sector if they were more educated, wealthier, had lived in Mumbai for a shorter time, were older, or were Muslim. Within the public sector, women were more likely to use smaller institutions for prenatal care if they had more children, and for delivery if they had lived in Mumbai longer and had more children.

### Qualitative findings

We identified four conceptual processes in choosing a maternity care provider: exploring the options, defining a sphere of access, negotiating autonomy, and protective reasoning. Health care decisions took place in a context of uncertainty about provider competence, quality of services, and costs and outcomes of care. Strategies aimed at selecting the best or most suitable, accessible health care provider were used, with the underlying goals of ensuring positive health outcomes and avoiding poor quality care and experiences.

### Exploring the options

Women sought various types of information from relatives, friends and neighbours to identify suitable (and unsuitable) health care providers among unfamiliar alternatives. Suitability was categorised in terms of convenience, affordability, quality, and expected health outcomes. The extent to which women explored options depended on their existing knowledge and experience of maternity and health care. For example, primigravid women knew little about pregnancy and childbirth, and recent migrants had limited knowledge of health facilities and the quality of services: “We were new here ... we did not know anything about this place, which hospital is good.” Enquiring with familiar or trusted people provided information about appropriate options.

Then she told me ... “Go here [to this private hospital]. The thing is that less [money] will be required here. Today is Sunday. If you register today, you will have to pay 50 Rupees. If you go after today or any other day then they will take 250 Rupees, or whatever it is. And, sister, you don’t have the money.”

(Muslim, delivered at a private hospital)

Advice and recommendations influenced choices so that, “if she knows that this hospital is nice, then she will advise me to go there, and I’ll go.” Similarly, endorsement of a provider, such as, “My brother’s wife delivered a baby boy at this hospital and everything went well”, gave reassurances about a provider’s competence. Additional information, such as provider practices and fees, enabled families to incorporate dimensions of acceptability and affordability into their decisions.

**Table 2** Prenatal care site, by maternal characteristics, for 3819 deliveries in the two years preceding the census

	Total <i>n</i> (%)	<3 prenatal care visits <i>n</i> (%)	Prenatal care in private sector <i>n</i> (%)	Prenatal care in public sector	
				Prenatal care at tertiary public hospital <i>n</i> (%)	Prenatal care at smaller public facility <i>n</i> (%)
All	3819 (100)	242 (6)	1160 (31)	1880 (49)	537 (14)
Maternal education					
None or informal	1158 (100)	137 (12)	300 (26)	562 (49)	159 (14)
Primary	234 (100)	14 (6)	54 (23)	124 (53)	42 (18)
Secondary	2130 (100)	89 (4)	672 (32)	1065 (50)	304 (14)
Higher	297 (100)	2 (1)	134 (45)	129 (43)	32 (11)
Household asset quintile					
Quintile 1	765 (100)	114 (15)	152 (20)	377 (49)	122 (16)
Quintile 2	764 (100)	60 (8)	199 (26)	407 (53)	98 (13)
Quintile 3	772 (100)	37 (5)	225 (29)	395 (51)	115 (15)
Quintile 4	755 (100)	19 (3)	234 (31)	393 (52)	109 (14)
Quintile 5	763 (100)	12 (2)	350 (46)	308 (40)	93 (12)
Duration of residency in Mumbai					
Less than 1 year	258 (100)	61 (24)	63 (24)	115 (45)	19 (7)
1–4 years	864 (100)	67 (8)	296 (34)	399 (46)	102 (12)
5–9 years	557 (100)	35 (6)	173 (31)	262 (47)	87 (16)
10 years or more	2140 (100)	79 (4)	628 (29)	1104 (52)	329 (15)
Age					
Under 20	139 (100)	4 (3)	31 (22)	86 (62)	18 (13)
20–29	2823 (100)	166 (6)	846 (30)	1427 (50)	384 (14)
30–39	795 (100)	67 (8)	263 (33)	338 (43)	127 (16)
40–49	62 (100)	5 (8)	20 (32)	29 (47)	8 (13)
Parity					
1	1163 (100)	51 (4)	373 (32)	597 (51)	142 (12)
2	1007 (100)	49 (5)	297 (29)	518 (52)	143 (14)
3	758 (100)	53 (7)	217 (29)	372 (49)	116 (15)
4	405 (100)	26 (7)	123 (30)	195 (48)	61 (15)
5 or more	486 (100)	63 (13)	150 (31)	198 (41)	75 (15)
Religion					
Muslim	3161 (100)	198 (6)	1041 (33)	1523 (48)	399 (13)
Hindu	645 (100)	44 (7)	114 (18)	352 (54)	135 (21)
Other	13 (100)	-	5 (38)	5 (38)	3 (23)

Note: Information missing for 29 women

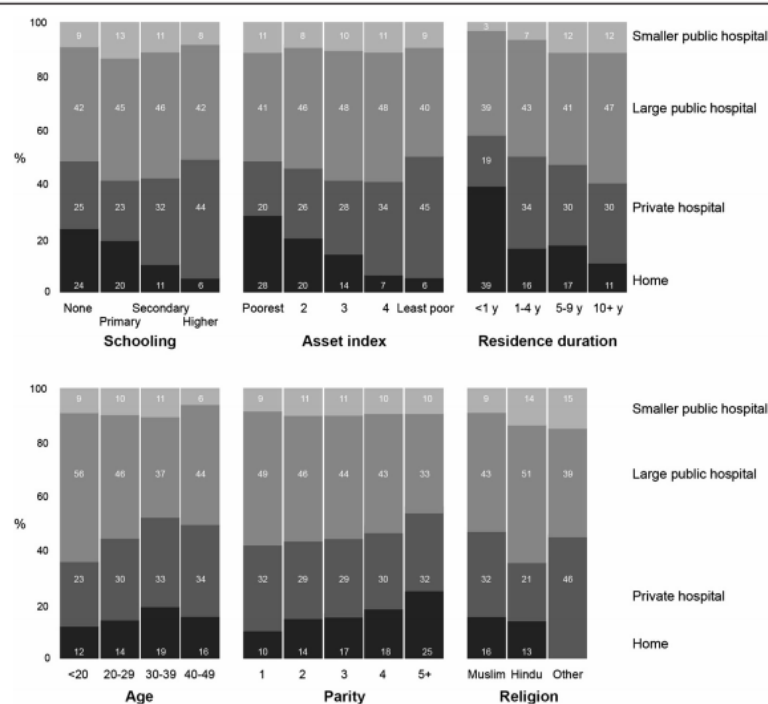
**Defining a sphere of access**

Economic and social status pervaded health care decisions. A convergence of household financial capacity and *aukaad* (social status) and the cost of care across sectors acted as a reference point from which families defined their sphere of access to care. Although the private sector was lauded because “the facilities are good, they give proper medicines and care”, utilisation was contingent on the sphere of access. Since women from lower economic

groups had a narrower sphere of access, their choices were usually limited to municipal facilities or inexpensive private providers.

We don't have the status to pay for private. Out of helplessness, one goes more to government.

(Focus group participant, home birth and public hospital delivery)



**Fig. 1** Delivery care site, by maternal characteristics, for 3820 deliveries in the two years preceding the study. Note: Information missing for 28 women

Because of all these [financial] problems, we have registered in a municipal hospital.

(Muslim, registered pregnancy at municipal peripheral hospital)

Some families used strategies to access the private sector, even temporarily. These included pooling or borrowing money, or switching sectors if private care became unaffordable.

If the time comes for a caesarean, because of money issues it has to be done in a municipal hospital ... because the operation isn't cheap, [privately] it costs 20–25 thousand Rupees. If we get it done in the municipality the expense will be less and [the money] can be used for food. So, we will have to think if the time comes for an operation.

(Muslim, registered pregnancy at a private clinic)

Besides the financial vulnerability families faced in balancing health care decisions against household sustenance, the excerpt illustrates the provisional and

situational nature of choice throughout the care trajectory: they were made according to current financial capacity and re-evaluated for each care-seeking episode or in the event of new financial or medical circumstances.

#### Negotiating autonomy

Seeking care involved mobilising financial and social resources, and decisions often had consequences for household functioning. Choosing an initial or different provider often depended on the women's ability to negotiate their economic and social conditions. Depending on the location and type of provider, besides the direct and indirect costs of care, relatives or friends were routinely required to accompany women to consultations or help out at home. Since institutional care involved absence from domestic work, potential disruption to the family also had to be considered.

If they had sent me to hospital F my husband would have spent all day travelling to and from the hospital. Not only would he lose an entire day at work, but



**Table 3** Odds ratios for uptake of prenatal care and institutional delivery, care in the public sector, and care at tertiary public hospitals, in the two years preceding the study, by maternal characteristics

	Prenatal care		Delivery care	
	OR (95 % CI)	aOR (95 % CI)	OR (95 % CI)	aOR (95 % CI)
	3 or more prenatal care visits (reference: <3 visits)		Institutional delivery (reference: home delivery)	
Maternal schooling (y)	1.17 (1.13, 1.22)	1.08 (1.04, 1.13)	1.13 (1.10, 1.16)	1.07 (1.04, 1.10)
Household asset quintile	2.46 (2.08, 2.90)	1.92 (1.59, 2.32)	1.95 (1.75, 2.18)	1.62 (1.43, 1.83)
Duration of residency (y)	1.06 (1.04, 1.08)	1.05 (1.03, 1.07)	1.04 (1.03, 1.05)	1.03 (1.02, 1.04)
Age (y)	0.96 (0.93, 0.98)	1.01 (0.97, 1.05)	0.96 (0.95, 0.98)	1.01 (0.98, 1.03)
Parity	0.81 (0.76, 0.86)	0.79 (0.72, 0.88)	0.84 (0.80, 0.88)	0.82 (0.76, 0.89)
Muslim faith	1.06 (0.72, 1.56)	1.11 (0.74, 1.66)	0.87 (0.65, 1.15)	0.90 (0.67, 1.21)
	Prenatal care in public sector (reference: private sector)		Delivery in public sector (reference: private sector)	
Maternal schooling (y)	0.96 (0.94, 0.97)	0.96 (0.94, 0.98)	0.96 (0.94, 0.98)	0.96 (0.94, 0.98)
Household asset quintile	0.72 (0.66, 0.79)	0.70 (0.63, 0.77)	0.73 (0.67, 0.80)	0.71 (0.64, 0.78)
Duration of residency (y)	1.01 (1.00, 1.02)	1.02 (1.01, 1.03)	1.01 (1.00, 1.01)	1.02 (1.01, 1.03)
Age (y)	0.98 (0.96, 0.99)	0.94 (0.92, 0.96)	0.97 (0.96, 0.99)	0.96 (0.93, 0.98)
Parity	0.99 (0.95, 1.04)	1.04 (0.97, 1.11)	0.96 (0.91, 1.00)	0.98 (0.92, 1.05)
Muslim faith	0.58 (0.45, 0.75)	0.51 (0.39, 0.67)	0.63 (0.49, 0.81)	0.58 (0.45, 0.75)
	Prenatal care at tertiary public hospital (reference: other public facility)		Delivery at tertiary public hospital (reference: other public facility)	
Maternal schooling (y)	1.02 (0.99, 1.05)	1.01 (0.98, 1.04)	1.01 (0.98, 1.04)	1.01 (0.97, 1.04)
Household asset quintile	1.02 (0.91, 1.16)	1.03 (0.90, 1.19)	1.03 (0.90, 1.18)	1.07 (0.92, 1.26)
Duration of residency (y)	0.98 (0.98, 0.99)	0.99 (0.98, 1.00)	0.98 (0.97, 0.99)	0.98 (0.97, 0.99)
Age (y)	0.97 (0.95, 0.99)	1.00 (0.97, 1.03)	0.98 (0.96, 1.01)	1.03 (0.99, 1.06)
Parity	0.88 (0.83, 0.94)	0.87 (0.80, 0.95)	0.88 (0.82, 0.95)	0.84 (0.76, 0.93)
Muslim faith	1.15 (0.87, 1.54)	1.30 (0.96, 1.76)	1.04 (0.74, 1.45)	1.20 (0.84, 1.70)

OR odds ratio from univariable logistic regression model with random effect for cluster, aOR adjusted odds ratio from multivariable logistic regression model, including the other independent variables and random effect for cluster, CI confidence interval, y years

even my children would be neglected. There would have been no one to look after me regularly there at hospital F. So, I chose this [private nursing home].

(Hindu, delivered at a private nursing home)

Health care choices, therefore, were considered within the economic condition of the household and the women's social position or had to be modifiable through negotiation. Those unable to mobilise sufficient resources to access a preferred provider compromised: "The hospital is near ... we can go and come back quickly and do our household chores." Women with better access to funds or greater social support and autonomy were able to select a preferred provider. One respondent, for example, chose her prenatal and delivery care with a well-known private doctor in a neighbouring district 12 h away by train.

#### Protective reasoning

Uncertainty about maternal health and health care caused fear and anxiety, and pregnancy and childbirth were

considered risky events. Care seeking often emphasised safety and positive health outcomes.

The delivery should be safe and successful. A woman is standing near the mouth of death [during pregnancy] ... *Allah tallah* (by God's blessings), hopefully everything should be fine.

(Mother-in-Law of a woman who delivered at a private facility)

Crucial to health care decisions and choice of provider were a "safe and successful" birth, protection against risk, and avoidance of negative experiences. Consultation with a trusted or reputable provider reassured families that complications would be avoided or resolved and, therefore, institutional care was the norm. Of 13 respondents who had delivered at home, only one had been planned. Other reasons included being unable to go to the hospital alone, being turned away from a health

facility either because the due date was later or the woman was not registered. In some cases, hospital staff had been unavailable or unwilling to attend to them at that time.

From their interactions with health care providers and services, women reconceptualised care, which informed subsequent care-seeking preferences and behaviour: positive experiences (e.g. attentive staff and competent doctors who “give good medicines,” and accessible, well-equipped hospitals in convenient locations) produced *attractive* responses, including repeating care at a previously-utilised facility. Negative experiences and perceptions (e.g. abusive provider behaviour, long queues and lengthy administrative procedures, or poorly-equipped hospitals) provoked *aversive* reactions and avoidance strategies.

I won't go to hospital F (municipal tertiary) ...  
because hospital F is very bad. If someone goes there,  
she doesn't return alive.

(Hindu, four deliveries in municipal peripheral hospitals)

Avoidance strategies usually involved discontinuing care with a provider and strategising to seek alternative care. One respondent ceased care at a public hospital because of exasperation with being “made to run around” while attempting to register for delivery. Other families sought loans to switch from public to private sector care. In one case, fear of being made to undergo caesarean section led one respondent to abandon all institutional care in favour of home birth.

## Discussion

Our study shows that institutional delivery is the norm in Mumbai's informal settlements. However, poorer and less educated women, and recent migrants were less likely to receive professional prenatal and delivery care. Tertiary public hospitals were a common source of maternity care across all socioeconomic groups. Private hospitals were popular with wealthier, more educated women.

We identified four conceptual processes central to choosing a health care provider: exploring the options, defining a sphere of access, negotiating autonomy, and protective reasoning. The overall aim was the selection of a suitable or best-option provider. Evidence of quality and positive outcomes encouraged women to seek care with certain providers while others were avoided or abandoned. Health care decisions and provider choice were mediated by household socio-economic status, the cost of care, and the ability of women to negotiate their social and economic environment.

The dominance of tertiary public hospitals as a preferred site of maternity care across socioeconomic groups is a problem for the equitable delivery of health

services to underserved areas: despite being located in proximity to poor neighbourhoods, poor perceptions of quality, limited services and understaffing in primary public health facilities often cause residents to bypass them in favour of tertiary hospitals. To most women, large hospitals symbolised comprehensive, integrated care, sophisticated equipment and technology, expertise and specialisation, where complications could be treated in one place. This made them attractive and convenient. At the same time, this preference exacerbates problems of overcrowding, longer waiting times, shorter consultations in tertiary facilities and loss of wages, dissuading some educated and wealthier people from utilising public sector health care [34].

Poor perceptions or experiences of care and fear of providers and practices were common reasons to avoid certain health facilities, especially in the public sector. Use of public sector service was often considered a consequence of “helplessness” or when “in trouble”. Several studies affirm the urban preference for the private sector [35–37]. Among the reasons for this are ease of accessibility, convenient timings, and a perception that the quality of care is better than in the public sector [38–40]. However, access to private health facilities is limited by the ability to pay; some women who had particularly poor perceptions or experiences of public sector care had either sought financial support from within the family or had taken a loan to avoid seeking care at a public hospital. Muslim women were more likely to seek prenatal and delivery care at private hospitals, reflecting a strong preference for female physicians [15, 41].

Uptake of institutional care was lower among recent migrants to Mumbai. Of women who had arrived within the last year, 24 % made fewer than 3 prenatal visits and 39 % delivered at home. A study by Stephenson and Matthews [42] found that rural–urban migrant women in Mumbai reported levels of prenatal care similar to urban non-migrants but substantially lower delivery care, suggesting that migrants assimilated the urban preference for institutional prenatal care while preserving the traditional practice of home birth. One explanation was that while social networks provided women with information to access prenatal care, they were also a resource for home-based delivery care [42]. In a study of two migrant groups in a Delhi slum, institutional maternity care became habitual when modern health services were available and considered effective. Lower exposure to health care in the place of origin and unfamiliarity with hospital care resulted in greater fear and distrust of institutional delivery. Conversely, greater autonomy and social interaction outside the home increased women's knowledge of health services and confidence to use them [12]. In our study, recent migrants had limited knowledge of health facilities and quality of services, and



weak social networks. This reduces access to information about available or appropriate care and made it difficult to mobilise support to choose from a wider pool of providers. Women often seek maternity care from specific, local private providers recommended by family and reported to offer good quality care.

Our study contributes to an understanding of disparities in the utilisation of institutional care in poor urban areas by considering the complexity of factors that influence uptake and choice of provider across public and private sectors. Its strengths were a relatively large sample and disaggregated data on utilisation patterns in both public and private sectors. Limitations included potential recall bias and 'best behaviour' bias regarding women's use of prenatal and delivery care. We have no reason to suspect that women gave false information, and the reported proportions of institutional care were similar to those in Mumbai slums as a whole [43]. Since we excluded families that were absent after the third visit, we might have missed some women who gave birth in their natal homes. A qualitative limitation arose from the use of quantitative and qualitative methods in grounded theory: we found it difficult to reconcile analytical concepts derived from deductive (quantitative) and inductive (qualitative) methods. We are continuing to develop our analysis into a substantive theory of provider selection.

Socioeconomic differentials manifest as inequities in the availability, affordability, and utilisation of health services [17, 44, 45]. The poorest are less able to pay for care because of disproportional health care costs from greater spending proportional to income, most of which have to be covered by wage income rather than savings [46]. Poorer groups, for whom good health and well-being are crucial for economic and household stability, often turn to more accessible, lower quality providers for their health care needs. They tend to consult with less competent practitioners who make less effort [47] or who operate in the largely-unregulated private sector. This is of concern because of the potential iatrogenic effects of over-medication, inappropriate treatment, or ignoring minimum standards of care [38, 48].

## Conclusions

In Mumbai's informal settlements, institutional maternity care is the norm. Individuals and families, even in the most disadvantaged groups, choose among health providers in both private and public sectors. However, socio-economic inequalities limit people's sphere of access and lead to differential utilisation across groups. Paradoxically, these inequalities make the selection of a suitable provider both more important and more difficult: more accessible practitioners are less likely to be fully qualified or trained, have lower competence and offer poorer quality care. Mitigating uncertainties about quality and safety compels many

families to engage in a complex decision-making process, mediated by their ability to mobilise social and economic resources, in an attempt to ensure positive experiences and outcomes of care.

Addressing health care disparities in underserved communities requires a clear understanding of how families choose among health care options. In addition to questions of service uptake, research in pluralistic urban settings must disaggregate information by level of health facility and type of provider across sectors. Improving women's choice and experiences of health care requires that health sector managers implement effective health system strategies, including high quality maternity services across sectors, a functioning regulatory mechanism, and monitoring of provider competences and behaviour.

## Competing interests

The authors declare that they have no competing interests.

## Authors' contributions

TH, DO, SD, and GA conceived and designed the study. DO, SD and GA developed the quantitative survey and the ODK interface. DO and SD did the statistical analyses, and DO, SD, GA and TH interpreted the data. GA, KH and SM designed the qualitative topic guides. KH and SM conducted the focus groups and interviews, transcribed them, and translated them into English and, together with GA, analysed the transcripts. GA wrote the draft manuscript, which all authors read and critically reviewed. SP is executive director of operations at the Society for Nutrition, Education and Health Action. TH, DO, SD, NSM, and GA had overall responsibility for the research project. All authors read and approved the final manuscript.

## Authors' information

Not applicable.

## Availability of data and materials

Not applicable.

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## Author details

<sup>1</sup>Institute for Global Health, University College London, 30 Guilford Street, London WC1N 1EH, UK. <sup>2</sup>Society for Nutrition, Education and Health Action (SNEHA), 310, 3rd Floor, Urban Health Center, 60 Feet Road, Dharavi, Mumbai 400 017, India. <sup>3</sup>Department of Public Health, Erasmus MC University Medical Center Rotterdam, P.O. Box 2040, 3000 CA Rotterdam, The Netherlands.

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## Appendix B. Letter of collaboration with SNEHA



**SNEHA** Society for Nutrition, Education and Health Action

[REG. NO. E-17858(MUM)]

Every woman and child counts.

**A case study of private medical practitioners and perinatal health care in two vulnerable areas of Mumbai.**

### FORMAL AGREEMENT OF COLLABORATION

This document outlines an agreement between SNEHA and Mr. Glyn Alcock, a research assistant and PhD student at the Centre for International Health and Development, UCL Institute of Child Health, United Kingdom.

- 1) Mr Alcock's research requires conducting research with various stakeholders in areas covered by SNEHA's City Initiative for Newborn Health (CINH) Project. He will be interviewing private health care providers, users of their services, members of medical associations, and other key informants. A proposal for his research has been presented to UCL and SNEHA.
- 2) UCL has been a partner of SNEHA's since 2005, collaborating in its interventions and research. Improving maternal and newborn health is one of SNEHA's key objectives, and private practitioners are an important source of health care in slum areas.
- 3) SNEHA's role would be to support Mr. Alcock's research by providing access to SNEHA's data and to community stakeholders. The Research Team would also give inputs to the study from time to time.
- 4) Mr. Alcock is required to keep SNEHA informed of his activities and take their inputs to ensure that the study is done in a scientific and ethical way and without creating any disturbance in the community or to SNEHA's work. Mr. Alcock has to ensure that his study represents collaboration rather than an extraction of data from the community. Mr. Alcock will share his research findings through oral presentations and drafts of written work, to allow SNEHA and others involved in the research to comment and challenge findings before any publication of material. Furthermore, he will submit to SNEHA a copy of his final thesis. If at any point either party feels uncomfortable or has concerns about the research they will be discussed at the earliest opportunity. SNEHA will use the study findings to inform its work on improving maternal and newborn health.
- 5) Mr. Alcock has approval from his supervisors to conduct his research and has full PhD status. He is seeking local ethical approval from the Anusandhan Trust Institutional Ethics Committee, after which he will approach the UCL Ethics Committee. The requirements and regulations of the approval will be binding on the research study.

1

Head Office : 4th floor, Urban Health Centre, 60 Feet Road, Dharavi, Mumbai 400017 • Tel: 24042627 • Fax: 24086011

Project Site : Behind Bldg. No. 11, BMC Colony, Shastri Nagar, Santacruz W. Mumbai 400054 • Tel: 26614488 / 26606295

Project Site : A/18, Kanara Business Centre, Laxmi Nagar, Chhatkopar E. Mumbai 400075 • Tel: 25007750 • Telefax: 25007751

Email: [snehamumbai@snehamumbai.org](mailto:snehamumbai@snehamumbai.org) • [www.snehamumbai.org](http://www.snehamumbai.org) • Crisis Centre: 24040045



## SNEHA Society for Nutrition, Education and Health Action

[REG. NO. E-17858(MUM)]

Every woman and child counts.

- 6) SNEHA will be credited in any publications and presentations involving Mr. Alcock's research. Mr. Alcock will be the primary author on any publication where he has taken the lead in conceptualisation and drafting. Co-authorship on such publications will be decided by Mr. Alcock in accordance with the conventions for authorship as set out by the International Committee of Medical Journal Editors ([http://www.icmje.org/ethical\\_1author.html](http://www.icmje.org/ethical_1author.html)).
- 7) Mr. Alcock will be responsible for maintaining the protection and confidentiality of any data generated in accordance with the approved protocol for his research.

Priya Agarwal

Operations Director

SNEHA, Urban Health Centre, 4<sup>th</sup> Floor, 60 Feet Road, Dharavi, Mumbai, India

July 20, 2010

Date

Ms. Neena Shah More

Research Director

SNEHA, Shastrinagar BMC Colony, Linking Road, Santacruz West, Mumbai, India

July 20, 2010

Date

Mr. Glyn Alcock

Research Assistant and PhD student

Centre for International Health and Development, UCL Institute of Child Health, United Kingdom.

July 20, 2010

Date

## **Appendix C. Participant information sheet for FGD/interview with women who accessed maternal health care**

### **Study Title: Maternal health care utilisation in urban informal settlements: a grounded theory**

#### **Introduction**

Hello, my name is \_\_\_\_\_. I work with the Society for Nutrition, Education and Health Action (SNEHA) in Mumbai. SNEHA has opened a project (SNEHA Centres) in this area to improve the health of women and children. We are doing a study to understand about which health facilities women accessed during pregnancy and for delivery. As a local resident, I would like to invite you to participate in the study. It is important that you understand the information provided here, including what your participation will involve. Please give your consent to participate only if you have understood the study and are aware of your rights as a participant.

#### **Purpose of the study**

The study is part of a larger research project by University College London and partners in Asia and Africa. It aims to understand the reasons why some women do not have the same access to health services as others. You are being invited to participate because you live in a SNEHA project area and are pregnant or have given birth, so you have valuable experience that would be useful to us.

#### **Study duration and number of participants**

The study will last for 6 months. You will be one of about 80 women selected to participate. We will also be interviewing these other women about their experience of accessing health services and also their family members, and other people in the community.

#### **Study procedures**

If you agree to participate I will ask you to attend a group interview of about 7-10 women in your area. I will ask you about the things that affected your experiences of maternal health services and your access to them. The interview will not take more

than one hour. I will audio record our interview to make sure that I do not forget or note any incorrect information.

### **Risks and benefits of participation**

Participation will not put you or your family at risk, although your family and neighbours may become aware of your participation. You can choose not to answer any question and you may stop the interview at any time. There are no financial or material benefits from participating in this study. The information you share will help us understand the experiences of women like you and will enable ours and other organizations to work better in the community in the future.

### **Right to withdraw from the study:**

Participation in the study is voluntary. You do not have to take part and you can withdraw at any time. Giving verbal consent means that you have understood the information about the study and that you agree to participate. You will be given a copy of this information sheet to keep.

### **Confidentiality**

Your participation in the study will be treated confidentially and any information which might identify you, your family or other individuals will be removed. All information and audio recordings will be safely stored and will not be shared with others. The information you do share will be used to write the study; some information may be published in international journals. However, the names of people and places will be removed or changed to protect your and your family's identity.

### **Contact for further information**

Thank you for taking the time to read, or have read to you, the information about this study. If you agree to participate, you should ask me anything that you do not understand before giving consent. You can also contact Neena Shah More at SNEHA on 26614488 at any time during the study.

This study has been approved by the Anusandhan Trust Institutional Ethics Committee and the Ethics Committee of University College London.

**Appendix D. Consent form for FGD/interview with women who accessed maternal health care**

**Study Title: Maternal health care utilisation in urban informal settlements: a grounded theory**

Thank you for your interest in taking part in this research. Before you agree to participate, the researcher must have explained the study to you. If you have any questions about the study, please ask the researcher before you decide whether or not to participate. You will be given a copy of the Information Sheet and this Consent Form to keep.

**The researcher is to place a ✓ or X against the following statements before the participant gives verbal consent:**

	<b>Statements by respondent</b>	<b>✓ or X</b>
1	The participant has read, or has been read, the Participant Information Sheet.	
2	The participant has been given a copy of the Participant Information Sheet.	
3	The researcher has informed the participant about the study including the nature, objective, benefits and risks, which he/she has understood.	
4	The participant has been given the opportunity to ask questions and has been given satisfactory responses.	
5	The participant understands that he/she is free to choose whether to participate or not in this study.	
6	The participant understands that he/she can withdraw from the interview or the study at any point.	
7	The participant understands that he/she will not be penalized for refusing to participate in the interview or for withdrawing from the study.	
8	The participant understands that his/her participation will be audio-recorded and consents to any intended use of the recordings for the study provided that his/her name and any personal identification are removed.	
9	The participant understands that his/her personal information will be treated as strictly confidential and that information which might identify him/her, his/her family, or other individuals will not be shared with others.	
10	The participant understands that any information he/she provides will be stored anonymously on a computer and may be used by	

	University College London or its partners for future work.	
11	The participant understands that the information he/she provides may be published in a report or study and that confidentiality and anonymity will be maintained so that it will not be possible to identify him/her.	
12	The participant understands that he/she can seek information, support or guidance from SNEHA about any questions or issues arising during the study.	

The participant has given verbal consent to participate in this study and understands that his/her consent is voluntary.

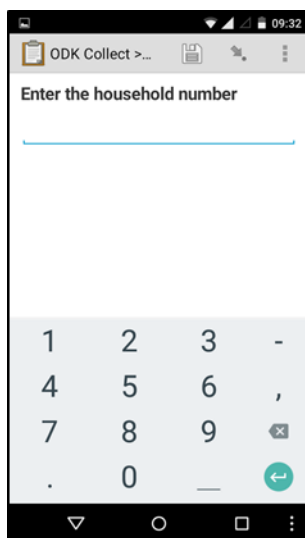
Signature of researcher: \_\_\_\_\_

Date \_\_\_\_ / \_\_\_\_ /2013

Respondent ID: \_\_\_\_\_

## Appendix E. Selected screenshots of SNEHA Centre baseline census questions

### A. Household registration: household number (English and Hindi)



ODK Collect >...

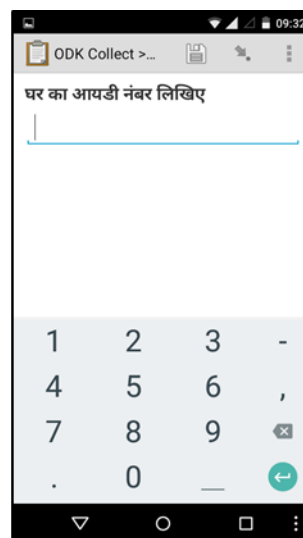
Enter the household number

1 2 3 -

4 5 6 ,

7 8 9 ✕

. 0 \_ ↩



ODK Collect >...

घर का आयडी नंबर लिखिए

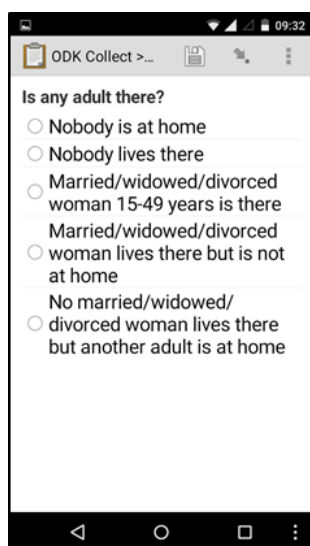
1 2 3 -

4 5 6 ,

7 8 9 ✕

. 0 \_ ↩

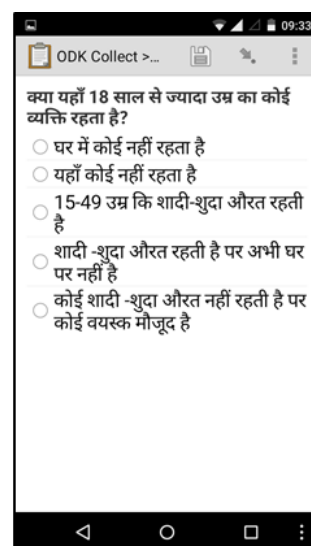
### B. Household member registration: occupancy (English and Hindi)



ODK Collect >...

Is any adult there?

- ☐ Nobody is at home
- ☐ Nobody lives there
- ☐ Married/widowed/divorced woman 15-49 years is there
- ☐ Married/widowed/divorced woman lives there but is not at home
- ☐ No married/widowed/divorced woman lives there but another adult is at home

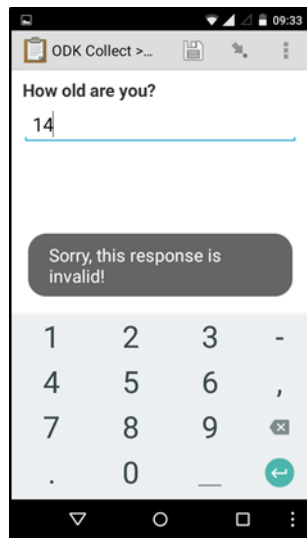


ODK Collect >...

क्या यहाँ 18 साल से ज्यादा उम्र का कोई व्यक्ति रहता है?

- ☐ घर में कोई नहीं रहता है
- ☐ यहाँ कोई नहीं रहता है
- ☐ 15-49 उम्र की शादी-शुदा औरत रहती है
- ☐ शादी-शुदा औरत रहती है पर अभी घर पर नहीं है
- ☐ कोई शादी-शुदा औरत नहीं रहती है पर कोई वयस्क मौजूद है

### C. Household member registration: built-in constraints



ODK Collect >...

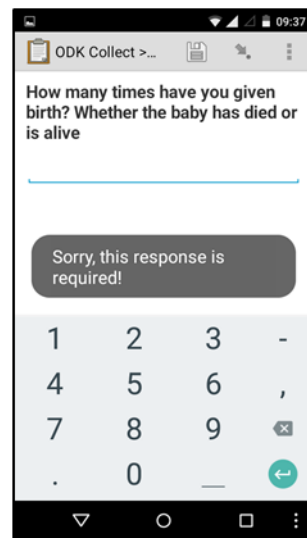
How old are you?

14

Sorry, this response is invalid!

1 2 3 -  
4 5 6 ,  
7 8 9 ×  
. 0 \_ ↩

This screenshot shows a mobile form titled 'ODK Collect >...'. The question is 'How old are you?'. The user has entered '14'. A grey message box says 'Sorry, this response is invalid!'. Below the message is a numeric keypad with digits 1-9, a decimal point, a minus sign, and a backspace key.



ODK Collect >...

How many times have you given birth? Whether the baby has died or is alive

Sorry, this response is required!

1 2 3 -  
4 5 6 ,  
7 8 9 ×  
. 0 \_ ↩

This screenshot shows a mobile form titled 'ODK Collect >...'. The question is 'How many times have you given birth? Whether the baby has died or is alive'. The response field is empty. A grey message box says 'Sorry, this response is required!'. Below the message is a numeric keypad with digits 1-9, a decimal point, a minus sign, and a backspace key.



## Appendix F. Community Resource Centre trial evaluation database design

Main respondent form

Question, <i>Hint</i>	Fieldname	Type	Req	Constraint / Options	Constraint message if outside range	Relevance
Questionnaire start time (HIDDEN)	timestart	Time		Interview start time		
Enter your ID number	interviewerid	Number	Y	1-24	Number must be between 1 and 24	
Enter the cluster number	clusterid	Number	Y	1-40	Number must be between 1 and 40	
Enter the household number	hhid	Number	Y	1-999	Number must be between 1 and 999	
Date of visit (HIDDEN)	datestamp	Date		Interview date		
Click the button to record the location of the household <i>Try to get a clear view of the sky and turn around until you get an accurate reading</i>	gps	Location	N			
Is this the first, second or third visit to this household?	visitnum	Select 1	Y	1 First 2 Second 3 Third		
Is any adult there?	visitadult	Select 1	Y	88 Nobody is at home 66 Nobody lives there 1 Married/widowed/ divorced woman 15-		

				49 years is there 11 Married/widowed/ divorced woman lives there but is not at home 2 No married/ widowed/divorced woman lives there but another adult is at home		
Is she available for interview?	visitwoman	Select 1	Y	1 Yes 0 No		/data/visitadult=1
Is an adult available for interview?	visit3adult	Select 1	Y	1 Yes 0 No		/data/visitadult=2 or (/data/visitnum=3 and /data/visitadult=11)
Interview possible (HIDDEN)	intposs	Number		1 Yes 0 No		if((/data/visitwoman=1 or /data/visit3adult=1),1,0)
Enter a date to visit again	revisitdate	Date	Y	. &gt; today()	You must enter a date in the future	/data/visitnum !=3 and (/data/visitadult=88 or /data/visitadult=11) or /data/visitnum !=3 and (/data/visitwoman=0 or /data/visit3adult=0)
Interviewer: Read the participant information sheet to the respondent	studyinfo	Text	N	Read only		/data/visitwoman=1 or /data/visit3adult=1
Do you agree to participate in the study	respconsent	Select 1	Y	1 Yes: Take signature 0 No		/data/visitwoman=1 or /data/visit3adult=1

Enter the respondent ID	respid	Number	Y	1-3	Number must be between 1 and 3	/data/respconsent=1
Interviewer: Is the respondent a man or a woman?	respsex	Select 1	N	1 Man 2 Woman		/data/respconsent=1 and /data/visitadult !=1
What is the name of the head of household?	hhname	Text	N	2-50 chars		/data/respconsent=1 and /data/respid <=1
Say to respondent: I am going to ask you about the people who live in your house, starting with you.	hhintro	Text	N	Read only		/data/respconsent=1 and /data/respid <=1
What is your name?	respname	Number	N	2-50		/data/respconsent=1
How old are you?	respage1549	Number	N	15-49	Number must be between 15 and 49	/data/respconsent=1 and /data/visitadult=1
How old are you? <i>If unknown, enter 99</i>	respage	Number	N	16-99	Number must be between 16 and 99	/data/respconsent=1 and (/data/visitadult=2 or /data/visitadult=11)
How many years of schooling have you had? <i>If less than 1st standard, enter 0. If unknown, enter 99</i>	respedu	Number	N	. >=0 and . <=19 or . =99	Number must be between 0 and 19, or 99	/data/respconsent=1
What is your main occupation?	respocc	Select 1	N	10 Does not work or looking for work 88 Student (school or college) 9 Job that does not require skills or training 8 Runs machines in a factory, or driver		/data/respconsent=1

				7 Makes products 6 Agriculture or fishery worker 5 Shop, market, hotel or transport worker 4 Junior white collar 3 Service sector skilled or technical work 2 Professional 1 Senior manager or government official		
What is your religion?	respreligion	Select 1	N	1 Muslim 2 Hindu 99 Other		/data/respconsent=1

<sup>1-4</sup> These sections are repeated for each of the men, women, boys, and girls who live in the household.

## **Appendix G. Topic guide for user of institutional maternal health care services**

### ***Guidance for interviewers***

The purpose of the study is:

To explore in detail how and why women and their families ***choose and utilise health care*** (institutions and practitioners) for antenatal and delivery care (for the last delivery within previous 2 years).

Introduce yourself to the respondent and explain the purpose of the study and why you have invited them for interview. Read the information sheet and obtain consent before starting the interview. Answer any questions the respondent has. Remember to test and start the voice recorder.

The questions below are only a guide. Probe issues for more detail. Use prompts such as: “Can you tell me more about that?”, “Can you tell me why that is?”

Ask for specific examples or experiences, for clarity and detail.

**Confirm general information - name, age, parity, education, religion, migrants how long have you lived here?**

### **Constructions and conceptualizations of ‘health care providers’**

Can you tell me about providers of maternal health care in Mumbai?

- Who are they?
- Where are they?
- Modern/traditional
- Type of medicine: Allopathic/Ayurvedic/Homeopathic/Unani
- Qualifications and training: formal/informal
- What makes a ‘good’ provider

### **Utilisation of health care provider for antenatal and delivery care**

- Can you tell me about your pregnancy and experience of antenatal care?
- How many check-ups did you have during the most recent pregnancy?  
Why this number of times?
- Did you experience any problems during pregnancy? What were they and what did you do?
- Where did you seek health care: type of provider (public/private; large/small clinic; formal/informal provider)?
- Antenatal care:
  - i. Name of provider: \_\_\_\_\_

- ii. Location (be precise): \_\_\_\_\_
  - iii. Did you go to more than one provider? Who? Why?
  - iv. What information, advice, and orders did the provider give you?
- Delivery:
  - i. Name of provider: \_\_\_\_\_
  - ii. Location (be precise): \_\_\_\_\_
  - iii. Did you go to more than one provider? Who? Why?
- For your last pregnancy, what factors did you consider important when deciding which provider to use for antenatal care and delivery? Examples, do not prompt.
  - a. Distance: how far is acceptable? Why? Under what circumstances would/did you travel far?
  - b. Costs: what were they? How much is expected? Is 'cost effectiveness' important?
  - c. Availability of provider: facility timings, patient load, on-call doctor?
  - d. Perception of the provider
    - i. 'Good' or effective provider: why? What do these terms mean?
    - ii. Knowledge: of what?
    - iii. Aptitude: what?
    - iv. Attitude and behaviour: what?
    - v. Rapport, trustworthiness etc: how is this assessed?
    - vi. Personal Characteristics of doctor, nurse and other staff (e.g. admin): gender, age, ethnicity, language.
  - e. Quality of care (who they see, what the doctor/nurse does and what procedures are done (e.g ultrasound) and whether they are ok with the way it is done, how the staff talk to and interact with them)
  - f. Time it takes to consult (travel, waiting, procedures in the clinic)
  - g. Type of medical practice (allopathy, homeopathy, etc)
  - h. Personal preference (e.g. private care, one-stop-shop)
  - i. Effective/dangerous: in what way? Why? (Practices that can be potentially risky or effective).

### **Perceptions about maternal health care**

How do you view the role of the health care provider (hospital/clinic, gynaecologist/doctor, nurse) in providing you with maternal health care?

- What do you expect from an antenatal consultation/delivery?
- What do you expect from the providing institution and staff?
- Have your expectations usually been met?
- What is good quality care?

### **The process of choosing a health care provider for antenatal and delivery care**

- Who all were involved in choosing a provider(s)?

- How did the selection process happen? Who was involved?
  - i. Family, friends neighbours
  - ii. A 'specialist'
- Consulting with people who might be able to help or know someone *to make things easier* – *who are these people and what is their affiliation/connection?*

**If we were to develop a leaflet what kind of information would you like to have on it (this is to comply with the local ethics committee recommendation)?**

## **Appendix H. Topic guide for focus group with women who delivered at home**

### **TOPIC GUIDE – Women who delivered at home**

The purpose of the study is:

To explore in detail how and why women and their families choose particular health care providers (institutions and practitioners) for antenatal and delivery care (for the last delivery within previous 2 years).

Guidance: Introduce yourself to the respondent. Explain the purpose of the study and why you are there. Read the information sheet and obtain consent before starting the interview. Answer any questions the respondent has. Remember to check and start the voice recorder before starting the group discussion.

The questions below are to be used as a guide. Probe for more detail. Ask, “Can you tell me more about that?”, “Can you tell me why that is?”

Ask for specific examples or experiences, for clarity and detail.

1. General information - name, age, parity, education, religion, migrants how long have you lived here?
2. Where do women in this area go for their deliveries? (Natal or maiden home/government facility/private facility/home in Mumbai)?
3. What are the reasons for choosing one of these places of delivery? (cost/distance/no-one to accompany /safety etc.)
4. Can you tell me how you come to have a home delivery? (Previous deliveries, experiences, decision making, economic, knowledge, distance, recommendation, trust factor, previous use of the health care provider, family's influence etc.)
5. Planned vs. unplanned home birth
6. Visits to health care providers during pregnancy for any reasons/ANC (private/public hospitals, pharmacist etc.)
7. If had ANC, where, when, frequency of visits. Information received from doctor, procedures conducted, reasons for discontinuing going there, behaviour of doctor, cost, waiting time, no one to go with, loss of wages, children to take care of, no information, cultural factors, fear of procedures, etc.



## Appendix I. Data collection activities

Type of data collection (FGD, SSI) <sup>1</sup>	ID number	Date of data collection	Pseudonym of place name	Participant sampling criteria	Language of data collection
FGD-1 (n=10)	nbdedpphin0001	20-03-2013	Philadelphia	Any woman who had an institutional delivery in last 2 years	Hindi
FGD-2 (n=14)	nbdedpphin0002	21-03-2013	Manhattan	Any woman who had an institutional delivery in last 2 years	Hindi
FGD-3 (n=7)	nbcapuhin0001	05-04-2013	Pennsylvania	Currently pregnant, prenatal care in public hospital	Hindi
FGD-4 (n=3)	nbcaprhin0001	13-04-2013	Pennsylvania	Currently pregnant, prenatal care in private hospital	Hindi
FGD-5 (n=9)	nbdehbrhin0001	21-05-2013	Philadelphia	Women who had 1 or more home births	Hindi
FGD-6 (n=6)	nbdenachin0001	27-05-2013	Pennsylvania	Women who had no prenatal care (note: 4 had had prenatal care)	Hindi
FGD -7(n=7)	nbdeapuhin0001	28-05-2013	Manhattan	Delivered and had prenatal care in peripheral municipal facility	Hindi
FGD-8 (n=5)	nbcohin0001	28-05-2013	Albania	SNEHA Community Organizers	Hindi
SSI-1	nbmlaprhin0001	02-05-2013	Pennsylvania	Mother-in-law of pregnant woman having private prenatal care	Hindi
SSI-2	nbdedprhin0001	11-06-2013	Czechoslovakia	Muslim, lowest SES, delivered in private hospital	Hindi
SSI-3	nbdedprhin0002	11-06-2013	Czechoslovakia	Muslim, highest SES, delivered in private hospital	Hindi
SSI-4	nbdedpuhin0001	21-06-2013	Czechoslovakia	Muslim, lowest SES, delivered in public hospital	Hindi
SSI-5	nbdedpumar0001	21-06-2013	Czechoslovakia	Hindu, high SES, delivered in public hospital	Marathi
SSI-6	nbcapuhin0002	01-07-2013	Cleveland	Muslim, currently pregnant. Prenatal care in municipal hospital	Hindi

SSI-7	nbdehbrhin0002	03-07-2013	Philadelphia	Muslim, no education, delivered at home	Hindi
SSI-8	nbdehbrhin0003	13-07-2013	Philadelphia	Muslim, secondary education, delivered at home	Hindi
SSI-9	nbdedprhin0003	17-07-2013	Czechoslovakia	Muslim, no education, delivered in private hospital	Hindi
SSI-10	nbdedprhin0004	17-07-2013	Tokyo	Muslim, higher education, delivered in private hospital	Hindi
SSI-11	nbdedpumar0002	23-07-2013	Spain	Hindu, high SES, delivered in public hospital	Marathi
SSI-12	nbdedpumar0003	23-07-2013	Spain	Hindu, low SES, delivered in public hospital	Marathi
SSI-13	nbdedprmar0001	26-07-2013	Spain	Hindu, high SES, delivered in private hospital	Marathi
SSI-14	nbdedprmar0002	26-07-2013	Spain	Hindu, high SES, delivered in private hospital	Marathi
SSI-15	nbdedprmar0003	06-08-2013	Argentina	Hindu, high SES, delivered in private hospital	Marathi
SSI-16	nbdedpuhin0002	06-08-2013	Argentina	Hindu, mid SES, no education, delivered in public hospital	Hindi
SSI-17	nbdedpuhin0003	07-08-2013	Argentina	Hindu, high SES, low education, delivered in public hospital	Hindi
SSI-18	nbdedpuhin0004	07-08-2013	Argentina	Hindu, mid SES, low education, delivered in public hospital	Hindi

<sup>1</sup> FGD: focus group discussion; SSI: semi-structured interview

## Appendix J. List of participants and selected characteristics

FGD/SSI number <sup>1</sup>	Participant	Age group	Education	ANC site	Delivery site (or status)	Parity	Quintile	Religion	Years in area
FGD-3	R1	20-24	Unknown	Peripheral public	Pregnant	Unknown	Unknown	Muslim	Unknown
	R2	20-24	Unknown	Large public	n/a	1	Unknown	Muslim	Unknown
	R3	20-24	Unknown	Private hospital	n/a	1	Unknown	Muslim	Unknown
	R4	25-29	Unknown	Large public	n/a	1	Unknown	Muslim	Unknown
	R5	20-24	Unknown	Large public	n/a	1	Unknown	Muslim	Unknown
	R6	20-24	Unknown	Large public	Primigravid	0	Unknown	Muslim	1-5
	R7	20-24	Unknown	>1 facility (private & public)	Primigravid	0	Unknown	Hindu	Unknown
FGD-4	R1	25-29	Primary	Private hospital	n/a	1	Unknown	Muslim	>10
	R2	<20	Primary	Private hospital	Primigravid	0	Unknown	Muslim	>10
	R3	20-24	Primary	Private hospital	Primigravid	0	Unknown	Muslim	1-5
FGD-5	R1	25-29	None/ informal	Unknown	Home	4	2	Muslim	>10
	R2	35-39	Primary	Unknown	Home	6	Unknown	Muslim	>10
	R3	35-39	Secondary	Unknown	Home	7+	2	Muslim	>10

	R4	30-34	None/ informal	Unknown	Home	6	Unknown	Muslim	>10
	R5	25-29	College	Unknown	Home	3	Unknown	Muslim	1-5
	R6	30-34	None/ informal	Unknown	Home	4	2	Muslim	1-5
	R7	Unknown	None/ informal	Unknown	Home	7+	Unknown	Muslim	6-10
	R8	30-34	None/ informal	Unknown	Home	4	Unknown	Muslim	>10
	R9	25-29	None/ informal	Unknown	Home	5	Unknown	Muslim	1-5
FGD-6	R1	20-24	Secondary	Peripheral public	Unknown	0	Unknown	Muslim	>10
	R2	20-24	Secondary	None	Unknown	1	Unknown	Muslim	>10
	R3	25-29	Secondary	Private hospital	Large public	2	Unknown	Muslim	>10
	R4	20-24	Secondary	Peripheral public	Unknown	1	Unknown	Muslim	1-5
	R5	35-39	None/ informal	None	Unknown	4	Unknown	Muslim	1-5
	R6	25-29	College	None	Unknown	2	Unknown	Muslim	<1
FGD-7	R1	30-34	Unknown	Peripheral public	Home	5	Unknown	Hindu	>10

	R2	30-34	Unknown	Peripheral public	Peripheral public	5	Unknown	Muslim	>10
	R3	<20	Unknown	Peripheral public	Peripheral public	1	Unknown	Hindu	>10
	R4	Unknown	Unknown	Peripheral public	Home	5	Unknown	Hindu	1-5
	R5	25-29	Unknown	Peripheral public	Outside Mumbai	2	Unknown	Muslim	1-5
	R6	30-34	Unknown	Peripheral public	Peripheral public	3	Unknown	Unknown	>10
	R7	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Muslim	Unknown
FGD-8	Community Organisers	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
SSI-1	nbmlaprhin0001	No data	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown
SSI-2	nbddedprhin0001	25-29	None/ informal	Private hospital	Private hospital	4	1	Muslim	6-10
SSI-3	nbddedprhin0002	25-29	Secondary	Private hospital	Private hospital	4	4	Muslim	>10
SSI-4	nbddedpuhin0001	25-29	None/ informal	Peripheral public	Peripheral public	3	1	Muslim	1-5
SSI-5	nbddedpumar0001	25-29	Secondary	Large public	Large public	3	4	Hindu	>10
SSI-6	nbcpapuhin0002	<20	Unknown	Peripheral public	n/a	0	Unknown	Muslim	1-5
SSI-7	nbdehbrhin0002	30-34	None/ informal	None	Home	4	Unknown	Muslim	>10
SSI-8	nbdehbrhin0003	25-29	Secondary	None	Home	1	Unknown	Muslim	>10

SSI-9	nbdedprhin0003	20-24	None/ informal	Private hospital	Private hospital	2	4	Muslim	6-10
SSI-10	nbdedprhin0004	25-29	College	Large public	Outside Mumbai	2	Unknown	Muslim	6-10
SSI-11	nbdedpumar0002	25-29	Secondary	Peripheral public	Peripheral public	4	4	Hindu	>10
SSI-12	nbdedpumar0003	30-34	None/ informal	Peripheral public	Peripheral public	3	2	Hindu	1-5
SSI-13	nbdedprmar0001	35-39	Secondary	Peripheral public	Private hospital	5	4	Hindu	>10
SSI-14	nbdedprmar0002	25-29	Secondary	Private hospital	Private hospital	4	4	Hindu	>10
SSI-15	nbdedprmar0003	30-34	College	Private hospital	Private hospital	0	5	Hindu	1-5
SSI-16	nbdedpuhin0002	25-29	None/ informal	Peripheral public	Large public	4	3	Hindu	6-10
SSI-17	nbdedpuhin0003	25-29	None/ informal	Large public	Large public	2	4	Hindu	1-5
SSI-18	nbdedpuhin0004	20-24	Secondary	Peripheral public	Peripheral public	4	3	Hindu	6-10

<sup>1</sup> Information for FGDs 1 and 2 is omitted because participant data were not collected.

## Appendix K. Example of a lower quality interview transcript

ID number	nbdehbrhin0002
Site	Respondent's home
Type of data collection	In depth interview
Phase of data collection	Phase B
Date of data collection (English YYMMDD)	13/07/03
Pseudonym for place name	Philadelphia
Gender of participants	Female
Sampling criteria	Women who is scared of hospital
Data collector name	Sharda
Observer	None
Language of data collection	Hindi
Number of Participants	1
Respondent identity*	See Table below

**Interview No:** nbdehbr0002

**Interview type:** In depth interview

**Date:** 13/07/03

**Scheduled Start Time:** 3:32 PM

**Scheduled Duration:** 57 minutes

**Actual Start Time:** Missing

**Actual End time:** Missing

**Actual Duration:** 57 minutes

**Location:** Home of the respondent, Zakir Hussain Nagar

**Participants:** R1

Name	R1	R2
Age	30	26
Religion	Muslim	Muslim
Parity	4	1
Education	Nil	7
Currently pregnant	No	Yes
Home births	Yes-All births	Yes
Hospital births	No	Yes
Hospital for ANC	Never went for ANC	Never went for ANC
Age of the youngest child	5 months	2 years

## Observations

The respondent was sleeping when the investigator and I reached her home. Although we were told that the respondent wanted us to interview her at 3'0 clock, when we went there she was sleeping at the time. When we arrived she was very irritated because she thought that we disturbed her sleep. When she recognised me, she let me come inside her room. Then she asked me to conduct the interview. She was giving responses to me, but it was really difficult to hear all the responses as very loud music was being played.

There was another woman in the respondent's home who was actually her neighbour who was continuously increasing the volume of her TV while I was asking the questions. Instead of requesting her many times to reduce it, she was not reducing the volume of the TV. So, I was not able to concentrate on the interview. The neighbour tried to interrupt us but the respondent was contradicting her views. Sometimes, the neighbour answered the question instead of the respondent so I mentioned her as the second respondent in this interview. However, although she was responding to what I was asking R1 she was not interested in answering the questions asked separately to her. So I didn't ask her many questions. At one instance, she asked both of us to leave the room, go out and then discuss as she wanted to watch the movie on TV. At the end of the interview, she immediately got up so that she could close the door and then watch the movie without disturbance.

The respondent, who was very aggressive in the beginning, slowed down as the interview progressed. I wanted to know why she was scared of hospitals. The answers are in the interview but, in addition to this, it is also understood as to why she prefers delivering at home and why she prefers the *dai* over a doctor or nurse.



1 **I:** Now, you tell me your delivery happened to be at home no, so would you like to  
2 tell me in detail like how it happened to be a home delivery?  
3 **R1:** That's the only thing that I did not register my name ... [actually] I register my  
4 name but I am scared of going to hospital. Firstly they use a blade, this is all what I  
5 hear. I haven't seen it only heard that they use a blade. That's why all it happened to  
6 be at home. I don't go to hospital.  
7 **I:** So, do you register your name?  
8 **R1:** Yes  
9 **I:** So, then where do you register your name?  
10 **R1:** This one no [shows her youngest baby], at the time of this youngest one, when  
11 she was born  
12 **I:** Yes  
13 **R1:** So this doctor no Dr. Sam, he is Muslim  
14 **I:** Who?  
15 **R1:** Here is one doctor (A hawker shouts in the background)  
16 **R2:** Here is that Sam doctor no  
17 **I:** Sam doctor I don't know.  
18 **R1:** Oh this one only no  
19 **I:** Is it a big hospital?  
20 **R1:** No no, this is a small one. This is here only next to Hotel.  
21 **I:** Ok  
22 **R1:** So he only gave injection to me. I mean the injection of pregnancy [she meant  
23 the injection which is given at the time of pregnancy] was given to me after the  
24 delivery.  
25 **I:** OK, so did they give you injection?  
26 **R1:** Yes  
27 **I:** You registered their [in Dr. Sam hospital] itself?  
28 **R1:** Name means register means?  
29 **I:** Means now you said no, you go to hospital, so...  
30 **R1:** Yes this M (Hospital)  
31 **I:** Ok, in M (Hospital), you registered, so you didn't go to M hospital for the  
32 delivery?  
33 **R1:** No  
34 **I:** Why?  
35 **R1:** I get scared, I don't go there, this is the only.  
36 **I:** So your children...how many children do you have?  
37 **R1:** Four  
38 **I:** I have four children  
39 **R1:** All the four  
40 **I:** All the four have been born at home?  
41 **R1:** All four have been born normally, not to tell lie. The eldest one was also born  
42 normal.  
43 **I:** No means, all have born at home only?  
44 **R1:** Yes, all at home  
45 **I:** All no?  
46 **R1:** Yes, all at home  
47 **I:** Is this the youngest child?  
48 **R1:** Yes this is the youngest baby.  
49 **I:** what is her age?  
50 **R1:** She is 5, 5 months old

51 **I:** 5 months ok  
52 **R1:** Yes, of 5 months.  
53 **I:** And then Ok... and then you registered your name in M (hospital) during all of the  
54 deliveries, for this one [the youngest one] also?  
55 **R1:** No, not during the time of this [youngest] one.  
56 **I:** During your last delivery you didn't even register your name?  
57 **R1:** No, during her time neither did I register my name anywhere nor did I have any  
58 medicines, absolutely nothing.  
59 **I:** So how did you take care [prenatal care]?  
60 **R1:** We leave everything to god's will, that's it.  
61 **I:** So have you never been to a hospital?  
62 **R1:** No, only this time around I didn't go, but for all my previous 3 deliveries I went  
63 to the hospital.  
64 **I:** So you didn't go to hospital at all?  
65 **R1:** No, I didn't go. Neither did I register my name nor did I have any medicines or  
66 injection shots.  
67 **I:** But you said you went to [hospital] M and you also registered your name there...  
68 **R1:** That was during this [second child] time.  
69 **I:** So you didn't register your name during this one?  
70 **R1:** Yes, I didn't register my name during this [youngest] delivery. Why should I lie  
71 about it to you? I haven't registered my name at any hospital but I went there to  
72 register during this delivery, but they asked me how many kids I have, I have three  
73 children before this one. I said it's my second child but they said it's my third child  
74 and therefore I shall have to pay a fine of 500 rupees in order to go ahead with the  
75 delivery at the hospital. So if it's your third child then post the delivery they charge  
76 you Rs. 500 right?  
77 **I:** Looks blankly at R  
78 **R1:** They charge you at M (hospital).  
79 **I:** Sorry, I don't know.  
80 **R1:** At (hospital) M, for the delivery of the third child they fine you 500 rupees.  
81 **I:** Okay, so they fine you, is that why you didn't register your name?  
82 **R1:** I tried but the sisters didn't register my name there.  
83 **I:** Why didn't they register?  
84 **R1:** They told me it's yours 8<sup>th</sup>, 8<sup>th</sup> month of pregnancy...  
85 **I:** Okay...  
86 **R1:** So, they didn't register my name. So since I couldn't register my name there, I  
87 never went there again.  
88 **I:** And this was at this time [youngest one]?  
89 **R1:** Yes during this time [youngest one].  
90 **I:** So you did go to the hospital during the 8<sup>th</sup> month [of pregnancy] no?  
91 **R1:** Yes, [I went there] during my 8<sup>th</sup> month.  
92 **I:** So [you] went there [when you were] in your 8<sup>th</sup> month [of pregnancy], and they  
93 said that they will not take you?  
94 **R1:** Yes, they said that I have almost entered my 9<sup>th</sup> month of pregnancy...  
95 **I:** So they don't register your name if you are in your 9<sup>th</sup> month of pregnancy?  
96 **R1:** Yes, they don't register.  
97 **I:** Why don't they register?  
98 **R1:** Who knows?  
99 **I:** Did you feel the need to go to the hospital during your pregnancy?

100 **R1:** Hmm...Now even if I go I don't want (one statement's meaning is unclear) now  
 101 even if I had my name registered I wouldn't have gone there.  
 102 **I:** Why wouldn't you go there?  
 103 **R1:** I'm very scared  
 104 **I:** Why were you scared? (I wasn't able to concentrate because of the sound of the  
 105 television and the kid trying to sit on my lap).  
 106 **R1:** They cut with blade. Then what is said that, they stitch it, so that's why I'm very  
 107 much scared of all these things.  
 108 **I:** Cut with a blade?  
 109 **R1:** They use a blade no at the time of first baby  
 110 **I:** OK, so for the first baby, they use a blade. For the rest of the babies, they don't  
 111 use?  
 112 **R1:** (R nods a no).  
 113 **I:** But you have delivered three [babies] no, then?  
 114 **R2:** But still she is scared...  
 115 **R1:** Even then I'm scared; I don't go to the hospital.  
 116 **I:** But usually they don't use a blade if you undergo delivery for the fourth time or  
 117 do they?  
 118 **R1:** But I didn't go [to hospital] no, I didn't go there at the time of this [fourth baby].  
 119 I hadn't even registered my name, I didn't do anything yet I successfully had a home  
 120 birth.  
 121 **I:** You successfully gave birth at home? How did it happen? Did you call a *dai*  
 122 (midwife) over for assistance?  
 123 **R1:** Yes, I had summoned a *dai* (midwife), paid 2000 rupees [as her fees]. She had  
 124 cut the umbilical cord (child cries).  
 125 **I:** Okay, so how was the umbilical cord cut?  
 126 **R1:** With a blade...  
 127 **I:** But she used a blade...she also used a blade then...?  
 128 **R1:** They cut the baby's umbilical cord that...  
 129 **I:** Yes  
 130 **R2:** It is here that the umbilical cord is situated... (Both the women showed I the  
 131 umbilicus of the child)  
 132 **R1:** This thing here that you can see...  
 133 **I:** Yes  
 134 **R1:** The umbilical cord of the baby...  
 135 **I:** Yes  
 136 **R1:** They cut that...  
 137 **I:** Okay, so they cut it using a blade, aren't you scared then?  
 138 **R1:** (No response)  
 139 **I:** So in the hospital...  
 140 (Neighbour cuts in between saying that if a cut is made to our own body then only  
 141 it'll hurt and it'll not hurt if a cut is made to someone else's body)  
 142 **I:** You said that they use a blade in the hospital, so where all do they make use of a  
 143 blade?  
 144 **R1:** I don't know that. I hear that.  
 145 **I:** What have you heard?  
 146 **R1:** That first they use a blade...and if the child doesn't come out then they do the  
 147 operation. The baby is born after the operation, they tear open  
 148 everything...everything...I have heard all this but I haven't been there or seen  
 149 it...but I told you what I have heard.

150 **I:** Is there anything else, like the doctor is a male doctor that's why you are scared?

151 **R1:** During the birth of this child, I had been to F (hospital), and during this one's

152 time I had registered my name at D (hospital) (child cries). During this one's time I

153 had registered my name at D (hospital). I started having labour pains during

154 Mohorum<sup>4</sup>. They arranged all the equipment and machines that were required and

155 then asked me remove my salwar<sup>5</sup>, which I did (child cries again)...then they asked

156 me to lie down on the bed. I stripped off my clothes, I removed my salwar and not

157 the kurta. They asked me to lie down [she was asked to remove her salwar]. They

158 brought the machine closer to my head. When I saw that there were male doctors

159 who would conduct [my delivery], I decided I wouldn't go to the hospital...and the

160 way I ran away from there, then I directly came home. As soon as I returned home I

161 gave birth to a baby boy... (Child is playing around the respondent).

162 **I:** So you fear the male doctors?

163 **R1:** Yes obviously, I feel shy in front of the male doctors...

164 **I:** Okay

165 **R1:** Don't the male doctors perform the delivery; do you think I haven't seen it?

166 (R & R2 begin to chat among themselves about the male doctors).

167 **I:** Are you scared of blades or [you are bothered] expenses also?

168 **R1:** No, it's not that I think about expenses, but if I prefer giving birth at home then

169 why should I go to the hospital.

170 **I:** So you wanted to give birth here [at home] only, is it? (Child cries 06:49)

171 **R1:** Yes, but now it's over, now I don't want more [children]

172 **I:** Now, you want no more children?

173 **R1:** Now not anymore [child], I'm done.

174 **I:** Are you taking anything [contraceptive measures] for that?

175 **R1:** I took an injection for it...

176 **I:** Oh, you took an injection, so did you go to a hospital to get it?

177 **R1:** Not over here, but I went to that doctor [Dr. Sam] ...

178 **I:** You went to Sam doctor's (clinic)? So you...

179 **R1:** For these three years...

180 **I:** So, when all these [children] were delivered at home, then what about injections

181 and...

182 **R1:** Everything... (Loud music in the background)

183 **I:** This kid was born at home, right?

184 **R1:** Hmm...

185 **I:** So after the baby is born then for taking injections for children and for yourself if

186 you get any health problem, do you go to a hospital?

187 **R1:** All the injections have been given to him. You are asking about these injections

188 after the delivery only no?

189 **I:** From where?

190 **R1:** *Dai* (midwife)

191 **I:** [You mean to say] after the *dai* hands over the baby [to you], she gives injections

192 also?

193 **R1:** By the time my delivery was completed, like say in the morning...by evening it

194 (youngest child) was born.

195 **I:** Hmmm...

<sup>4</sup> Mohorum: A sacred Islamic festival

<sup>5</sup> Salwar: Salwar is a loosely fitting pajama-like trousers

196 **R1:** Like if she is born in the evening at around 8 pm, thereafter in the morning the  
 197 doctor will come and give all the injections and leave.  
 198 **I:** Okay, so you have called the doctor at home?  
 199 **R1:** Yes, I called him over...  
 200 **I:** Do the doctors also come home?  
 201 **R1:** Yes they come home too.  
 202 **I:** Ok.  
 203 **R1:** I was given an injection...she was born, she was not given [injection] (R asks R2  
 204 ) do they give [administer injections] to newborn also? (R2 says that they don't).  
 205 **I:** What all does the *dai* do after coming there?  
 206 **R1:** What does she do?, the usual thing, cleaning everything in the same way that the  
 207 sister (at the hospital) like cleaning and giving a warm water bath to the newborn.  
 208 These are things that even a *dai* (midwife) does at home. So basically whatever is  
 209 done at the hospital, the *dai* performs the same tasks at home.  
 210 **I:** Okay...  
 211 **R1:** She (midwife) gives a warm water bath to the newborn...and also gives a bath  
 212 to me - to mother. It's like this.  
 213 **I:** Did your family people object to you, did they say like don't go to hospital?  
 214 **R1:** No, in fact they tell me [to go to hospital], but I don't like to go there.  
 215 **I:** So you yourself don't like to go to hospital?  
 216 **R1:** No, during her time my mother beat me so much. [I said] I won't go.  
 217 **I:** You're that scared of going to the hospital?  
 218 **R1:** I swear I didn't go there...  
 219 **I:** Are you so scared of the blade? Why are you so scared, what do you think they  
 220 would do with the blade?  
 221 **R1:** Now, I don't know [why I am so scared]. I have heard all of this though I  
 222 haven't seen it myself...  
 223 **R2:** Now, they cut like this [shows by fingers of one hand vertically on another  
 224 hand]  
 225 **R1:** Now, how would I know how they cut or tear it. I don't come to know anything  
 226 about it.  
 227 **I:** So what all have you heard? You just said that you haven't seen it though...  
 228 **R1:** Now whatever other women speak and discuss I repeat the same...  
 229 **I:** What do these women say that you got scared so much?  
 230 **R1:** They say that cut is made with the blades [during the delivery] it's painful, and  
 231 the cut is repaired with sutures without administering anaesthetics.  
 232 **R2:** Oh my god!  
 233 **R1:** Really, I'm not joking...someone said this to my woman [relative] that...it was  
 234 very painful. My Andrew's wife had 5 stitches; it was their first child (Child cries,  
 235 loud music). It was my *bhavaj* [husband's brother's wife]  
 236 **I:** Do you know why they make an incision with a blade?  
 237 **R1:** Yes tell me why do they make that cut?  
 238 **I:** No, [you said] those women say no [that a blade is used during a delivery], you  
 239 said no that you heard from them?  
 240 **R1:** Yes, why do they make that incision?  
 241 **I:** You tell me why do they make that incision with a blade?  
 242 **R1:** Now, who knows? I don't know.  
 243 **R2:** When the baby takes time to descend, that's when they make that incision...  
 244 **I: (to R)** Do you know why they make that incision with a blade?  
 245 **R1:** I don't know. Why do they make [an incision with a blade]?

246 **I:** Even I am not so sure why they cut [with blade]. Now you are saying no that  
 247 people told you that they use a blade during delivery...  
 248 **R1:** Yes I only hear...  
 249 **I:** Didn't the women tell you why this incision is made using a blade?  
 250 **R1:** Why they make a cut?  
 251 **I:** I'm asking you about it, if they told you or not...  
 252 **R1:** Said that only that it might not happen quickly [the baby takes time to descend]  
 253 then they make an incision with a blade, this happens. So, they say no that in the first  
 254 baby, it is necessary that they made a cut.  
 255 **I:** So they make that incision with a blade when it's the first baby, so during this  
 256 one's time [youngest child] do you think that you should have gone or not?  
 257 **R1:** (cuts in) [I] didn't go [to hospital], nor [did I] register my name...  
 258 **I:** Yes, but why didn't you go?  
 259 **R1:** I don't go there...  
 260 **I:** Because of the blade...  
 261 **R2:** (cuts in) It is the choice of the person; now she is scared of the blade and hence  
 262 didn't go...  
 263 **R1:** Yes I'm scared of that.  
 264 **I:** But what makes you so scared? There are so many people who go there and  
 265 deliver babies, then why are you so scared?  
 266 **R1:** If you can successfully deliver a baby at home then why even go to a hospital.  
 267 What is there in a hospital, the same...in hospital M if you're crying and dying in  
 268 pain...no one will come downstairs to attend to you, when everything is over that is  
 269 when they will come and stay next to you...  
 270 **I:** Oh, is this what they do in M [hospital]?  
 271 **R1:** Then what, you think I haven't seen this [happening]? I have seen this happen to  
 272 a lot of people. My elder *bhavaj* also told me the same thing that this is what  
 273 happens in there...  
 274 **I:** What did they do to her?  
 275 **R1:** What did I see, when the baby come out a little [crowning] so everybody comes  
 276 running over there, even if you are struggling with a lot of pain [alone inside the  
 277 ward]. I have seen this in private [hospital].  
 278 **I:** Then why didn't you register your name in a private (hospital)?  
 279 **R1:** I didn't register myself in a private (hospital)...  
 280 **I:** Why, is it because of the expenses?  
 281 **R1:** (Nods in a no)  
 282 **I:** Then what is it?  
 283 **R1:** I just didn't register my name there, that's it.  
 284 **I:** So when the stitches are put, do you think it is for the mother's good? Because  
 285 before the stitches they make an incision so that the baby passes through with much  
 286 ease and post the delivery they stitch it back, is this what you've heard?  
 287 **R1:** (No response)  
 288 **I:** So what have you heard? I mean I'm trying to ask you what you have heard from  
 289 other women [about the blade]  
 290 **R1:** This is all I have heard that for the first baby, they use a blade, they stitch it, they  
 291 don't anaesthetise. That's it and nothing else.  
 292 **I:** They don't anaesthetise?  
 293 **R1:** No they don't.  
 294 **I:** Do they just stitch the incision like that?  
 295 **R2:** *Allah* [Oh god!] How can they [do that]?

296 **R1:** I swear on God [they do it that way]. I'm not joking. You can ask anybody if  
 297 you want...  
 298 **I:** So they stitch like that [without administering anaesthesia]?  
 299 **R1:** No, but how would they administer anaesthetics and then stitch up...  
 300 **R2:** How come they don't?  
 301 **R1:** It cannot happen like this. There is no question about using anaesthetics [before  
 302 stitching], go and ask someone if you want...  
 303 **R2:** After the birth of the child, if they don't anaesthetise [lower the sensation], then  
 304 how would it pain? How high would be the intensity of pain? (Child says something  
 305 and tries to sit on I's lap).  
 306 **R1:** Now they [people] say no like it pains a lot. So, when it is paining severely, and  
 307 if the cut is given at that time, so then it would not come to know, no? When the cut  
 308 is made with the blade they say it pains; now I don't know, I never went [to the  
 309 hospital to see this] and I haven't seen this. So when the baby takes time to descend  
 310 then they quickly make an incision in all that pain...  
 311 **I:** Hmm...  
 312 **R1:** Isn't it?  
 313 **I:** Yes yes.  
 314 **R1:** And after that when the baby is born thereafter they stitch that incision, would  
 315 anyone come to know? Won't it pain [later]?  
 316 **I:** Yes it will hurt  
 317 **R1:** So then? This is the reason why I don't go there. Look here I got goose bumps,  
 318 which is why I don't go to the hospital.  
 319 **I:** Is it because it pains a lot?  
 320 **R1:** Yes, I'm scared...I heard a lot of these things (claps her hand)...if the delivery  
 321 happens successfully at home then why would one go to a hospital? It's too much  
 322 stress...  
 323 (R2 speaks with R)  
 324 **R1:** They make an incision, the moment the baby is delivered...if the delivery hasn't  
 325 still taken place (corrects herself), the woman will be in pain and during this time  
 326 they would immediately make an incision and quickly the baby would come out.  
 327 **I:** You saw this at hospital M?  
 328 **R1:** What?  
 329 **I:** You were saying earlier no, that you had taken your *bhavaj* (husband's brother's  
 330 wife) there, and the doctor didn't arrive, they came only after it the crowning started.  
 331 **R1:** That is what I have been telling that it is because of this that I don't go there as  
 332 there is no one around to look after you.  
 333 (R2 tries to clarify to R that I is asking if she has seen all of it herself).  
 334 **R1:** I haven't personally seen it, but if I had seen it myself I would never give birth  
 335 here, why am I having a home-birth then, I have heard a lot of things...  
 336 **I:** So when the *dai* (midwife) conducts the delivery, doesn't she use a blade?  
 337 (The neighbour says that the *dai* does not use a blade and performs the delivery  
 338 comfortably, the *dai* sits in front and then at the backside of the patient providing  
 339 comfort to the patient and then performs the delivery).  
 340 **I:** So the *dai* doesn't make use of a blade? Could you please lower the volume a bit?  
 341 (R2 reduces the volume of the TV by just one unit). So the *dai* takes out [the baby]  
 342 comfortably and thereafter you go to the hospital to take injections and what happens  
 343 after that?  
 344 (If you want you can call the doctor home to get that injection)  
 345 **I:** Okay.

346 (The youngest child wakes up from sleep and the respondent tries to put her back to  
 347 sleep).

348 **I:** Okay, this is what I was saying that you are scared no, so then what is it that you  
 349 are so scared? You said earlier that you heard something and since then you are  
 350 really scared, what is it that you heard?

351 **R2:** Oh God [the respondent seems to be irritated]

352 **R1:** Now, the whole world knows...that's why [I'm saying]. Everyone say that they  
 353 use blade if it is a first child. That is what I'm saying, it is therefore better for me to  
 354 give a home-birth. That is the best thing to do, who will go there all the way...

355 **I:** So, the baby is delivered comfortably at home? And the difference in delivering  
 356 the baby at home and at hospital is that you comfortably deliver the baby at home.  
 357 Okay so do you call the *dai* in advance?

358 **R2:** Like for instance if you are sitting across me and suddenly you go into labour  
 359 pain then the *dai* is immediately called for...

360 **I:** Okay, so the *dai* comes over?

361 **R2:** Yes, she comes over immediately.

362 **I:** And what about the hospital?...is it because the distance to the hospital is too  
 363 much or is it only because you're scared that you refuse to go to the hospital?

364 (The neighbour confirms that the respondent is scared only. Child talks something  
 365 incessantly).

366 **R1:** Which one, this M [hospital] is far? It's near only no.

367 **I:** I don't know...

368 **R1:** Haven't you ever been to [hospital] M, this M hospital?

369 **I:** No I have not been there.

370 (Child talks loudly)

371 **I:** I don't live here, so I don't know...

372 **R1:** That one there is the M hospital...

373 **I:** Okay, so you're not scared of the doctor, no? It is just that the use of blade makes  
 374 you scared?

375 **R2:** Obviously, why would anyone be scared of the doctor?

376 **R1:** (Nodded no)

377 **I:** So you don't fear the doctor but only the use of the blade scares you?

378 **R1:** Yes, Blade is the main thing here...

379 **I:** Is there any other reason why you don't go there, is it because they don't talk to  
 380 you politely or...?

381 **R1:** Yes they are very rude, they make use of such bad bad words, as if they have  
 382 never given birth, they are the ones who haven't experienced giving birth. Let it go  
 383 to hell. They act in such a way as if they have never delivered a child, such kind of  
 384 abusive language they use I can't tell you...

385 **I:** Who all talk like that?

386 **R1:** Sister (then corrects herself) these staff [*aaya*] I tell you...is this a joke that we  
 387 go for registering our names? Say so many bad things in such a way you should not  
 388 ask [about it]. Just ask these people what do they say. You like to sleep with the  
 389 husband, like to do [sex] with the husband. Is this is a good thing to say? Don't you  
 390 [the staff] sleep next to their husbands, don't you [the staff] like to have sex with  
 391 their husbands, tell me? If we don't have a child then it's a problem, if someone is  
 392 going to have a child then that is a problem, you tell me what can one do, where  
 393 should people like us go?

394 **I:** So that means they don't talk to you'll politely?

395 **R1:** No, that is also why I don't like to go to hospital M. This M hospital is very bad.



396 **I:** You had mentioned this particular doctor Sam, doesn't he perform deliveries?  
 397 **R1:** No, he doesn't perform deliveries. He only gives injections like he gave a  
 398 tetanus injection after my delivery.  
 399 **I:** Isn't there any other hospital in this vicinity where you could possibly go?  
 400 **R1:** Yes. There is one hospital Shanghai  
 401 **I:** Is this Shanghai hospital a private one?  
 402 **R1:** Yes, it is private.  
 403 **I:** Then do you think that you should have gone there since staff at hospital M is not  
 404 polite to their patients...  
 405 **R1:** Nodded no  
 406 **I:** Is this because of the blade thing?  
 407 **R1:** [It is used] here also no, it is used everywhere.  
 408 **I:** Yes, But you said that they use [a blade] only if it is first baby...  
 409 **R1:** At all these places it is said that if it's the first child then they use of a blade...  
 410 **I:** But this one is your fourth child no...  
 411 **R1:** Hmmm, now it's enough, I don't want anymore.  
 412 **I:** This one is your fourth child. Do you think you should have gone to the hospital?  
 413 **R1:** I never went there for any of my previous deliveries then why would I go now?  
 414 **I:** Okay, so that fear had set in hence you opted for a home-birth; since you got  
 415 comfortable with your first delivery you decided to deliver at home for the rest of  
 416 them...  
 417 **R1:** My eldest son was also born at home only, and one other son I had given birth  
 418 was at my in-laws place back in the village. He was born at home, he was born dead.  
 419 It was during my 8<sup>th</sup> month of pregnancy, my mother-in-law had inserted her hand  
 420 into my abdomen to pull the baby out, but it was born dead.  
 421 **I:** Okay.  
 422 **R1:** then there is a girl, and after the girl, one more time I had conceived, so I  
 423 consumed medicines and then aborted the baby. I did this three times. Then this is  
 424 the one [youngest], the last number.  
 425 **I:** So in total you have four children, one boy who is the eldest one, then...  
 426 **R1:** Yes I had one son.  
 427 **I:** ...then a girl  
 428 **R1:** No, then a boy who was born dead  
 429 **I:** Yes, right...  
 430 **R1:** Then I lost that baby-boy, the one who was born after my eldest son, he was  
 431 born dead. After that I had a baby-girl and then again I had a son. I aborted with the  
 432 help of medicines. Again one more time, I conceived, again I did the same [meaning  
 433 not clear] (R2 speaks in the background, I could therefore not concentrate on what  
 434 the respondent was saying).  
 435 **I:** Okay, so you aborted then  
 436 **R1:** Yes.  
 437 **I:** Three times  
 438 **R1:** Yes three times.  
 439 **I:** And this one is the third child? So in all you have three kids and I thought that you  
 440 have four children...  
 441 **R1:** I have four children, two boys and two girls...I mean twice-thrice I aborted the  
 442 pregnancies with the help of medicines, I conceive very frequently. Thrice before I  
 443 had medicines and aborted three pregnancies.  
 444 **I:** Okay, so you aborted thrice?  
 445 **R1:** Yes thrice.

446 **I:** And you had these four kids?  
 447 **R1:** Nods  
 448 **I:** Exactly that part I didn't grasp what you were telling me about the medicines. But  
 449 who prescribed or suggested you these medicines? Who gave you these?  
 450 **R1:** The doctor did...  
 451 **I:** So you had been to a doctor that time?  
 452 **R1:** Yes.  
 453 **I:** Ok, You told me that you don't have any problem with the hospital being near or  
 454 far...  
 455 **R1:** This one is close by...  
 456 **I:** No, what I mean is that you told me that you fear the use of blade. It's not  
 457 that...and you also told me that you fear going to a male doctor (child cries, and the  
 458 respondent is trying to pacify the child). You mentioned that you won't get the  
 459 delivery done if there is a male doctor there and you also said that it doesn't matter  
 460 to you if the hospital is located near or far away. You later also talked about hospital  
 461 M that doctors don't come unless they see the baby's head  
 462 **R1:** I was talking about the helper staff, I was referring to them.  
 463 **I:** No, but you had said this to me...  
 464 **R1:** Yes, I know, the baai (helper staff) don't come (to attend to the patient), they're  
 465 never on time. They're always busy chatting among themselves, do they ever attend  
 466 a patient?  
 467 (R talks with R2).  
 468 **R1:** You lay down there with pain, when the baby comes out a little bit, when he  
 469 starts crying, then only the staff wake up [to attend you].  
 470 **I:** Do the doctors come there at least?  
 471 (R2 again speaks something, and the child is mumbling)  
 472 **R1:** Now if I stay home I'm able to make some tea for my husband... (The neighbour  
 473 says in teasing manner that the only thing that the respondent likes is the tea given  
 474 by the *dai* and then both the respondent and the neighbour burst into peals of  
 475 laughter). If the tea is made, honey is added to the tea and then they drink it.  
 476 **I:** Yes, I wanted to ask you the same thing, you had mentioned earlier that you like  
 477 to give home-birth, so what is it that you like in a home birth?  
 478 **R1:** It's the tea, just the tea that I like; she prepares hot tea and immediately serves  
 479 it...(child cries)  
 480 **I:** Okay she gives you tea, what tea does she give you?  
 481 **R1:** Black tea...  
 482 **I:** How is it prepared, what all things are there in that black tea?  
 483 **R1:** What is there in that? There is coriander seeds...you know the coriander seeds?  
 484 **I:** Okay...  
 485 **R1:** Coriander seeds are put in it...  
 486 **I:** Okay...  
 487 **R1:** And then it is filtered, after that; you know the thing which is put on bread that  
 488 is butter (The neighbour says it is ghee)  
 489 **I:** Okay, yes, yes, yes  
 490 **R1:** It is added into the tea because it's greasy hence it is healthy for the baby too...  
 491 **I:** So when it starts paining, *dai* comes and gives the tea?  
 492 **R2:** As soon as you get labour pains she begins to give you tea, no matter how bad  
 493 the pain is, she will ask you to have that tea...  
 494 (loud music).

495 **I:** Okay so it is like when you feel that it is time for your delivery, and you start  
 496 having labour pains, that you call the *dai* and she comes and gives you tea within  
 497 frequent intervals.

498 **R1:** The pain is felt every 5 minutes, so she gives the tea every time it pains and says  
 499 dear, keep drinking this and you will be able to deliver faster.

500 **I:** Does this tea help in faster delivery?

501 **R2:** When the pain starts, she understands this properly and do not use bad words.

502 **I:** Yes, that is what I am asking she treats you properly and?

503 **R2:** She even prays to God [for a successful delivery]...

504 **R1:** How you wish your God that please let me deliver quickly, likewise, we also  
 505 call a Muslim person.

506 **I:** Okay.

507 **R2:** They also call them, and we also call them, and they speak in legal terms...  
 508 (meaning unclear)...

509 **I:** When do you call them? I mean do you always call them in the event of a baby's  
 510 birth [so that all goes well]...what do you call them, *maulavi*?

511 **R1:** No, she is my *khala* (mother's elder sister).

512 **I:** So she gives blessings prays for you? When the baby is about to be born, she  
 513 prays for you.

514 **R1:** Yes

515 **I:** Inside the house...

516 **R1:** The way you people organize poojas and prayers, do you organize it or not?

517 **I:** Nodded yes...

518 **R1:** Your mother or sister might be praying to God that no matter what is the gender  
 519 of the child, just that the delivery should be over safely and comfortably, don't they  
 520 pray like that?

521 **I:** During all four of your deliveries, you call them? Is she your real sister?

522 **R1:** Yes.

523 **I:** Okay so the *khala* is the one who comes over and recites prayers on your behalf. I  
 524 just want to know what all things the *dai* do?

525 **R1:** She does the cleaning

526 **I:** Could you please lower the volume, I'm unable to hear what is being said...

527 **R1:** Please lower the volume there...

528 **I:** A little more please (asks the respondent to reduce the volume a little more)...So  
 529 what are the things that the *dai* does? One thing you said was that she prepares tea...

530 **R1:** Yes, she prepares the tea

531 **I:** She talks politely, and don't use bad words?

532 **R1:** Now that much [work which *dai* does] you call her at your home, that much  
 533 work won't be done by M [hospital], do they ask? When they are here at home, then  
 534 they will make you sleep [relax]... [with comforting words like] "Don't worry sister  
 535 everything shall be fine and happen soon".

536 **R2:** Means they will also massage the belly and legs?

537 **I:** What do you mean by that?

538 **R1:** This way... (Shows how the *dai* presses her legs). When the pain starts, don't  
 539 your legs feel the pain too? Does it pain or not? Reassure you [by saying] don't  
 540 worry everything will turn out to be fine in the end, and it will be quick.

541 **I:** That is what I want to know what exactly does the *dai* do? Because many people  
 542 say that *dai* does everything nicely.

543 **R1:** The *dai* does everything, like now in M hospital, baby is born, then the babies  
 544 are given bath, cleaned thoroughly.

545 **I:** Hmm.

546 **R1:** (inaudible) after she cleans the [newborn and the mother] thoroughly, then she

547 takes her fees and leaves...

548 **I:** So 2000 rupees are the expenses you incur towards the delivery?

549 **R1:** And then massage is given...

550 **I:** Yes, tell me more about it, what all she does?

551 **R1:** We call her twice for a massage...

552 **I:** Yes, you just told me that now...

553 **R2:** First she will massage the baby, and thereafter she'll give you [mother] a

554 massage, she does this for some 12 days or something...

555 **I:** Yes, so for how many days does she do this?

556 **R1:** During her time, I got the massages done for 4-5 days...

557 **I:** Does the *dai* charge you separately for the massages or is it inclusive of the 2000

558 rupees that you pay to her?

559 **R1:** Yes, it's all taken together. No, I mean for a delivery she will charge you 2000

560 rupees at that point and later you can call her over for the body massages, for which

561 she charges separately, something around 50 rupees once per day, and she charges

562 100 rupees if you ask her to come over twice a day. I mean for instance if you call

563 her in the morning then she will charge 50 rupees and if she's also asked to come in

564 the evening then that will be...

565 **I:** Then that will be 100 rupees.

566 **R1:** Yes, it will be 100 rupees

567 **I:** So these are charged separately?

568 **R1:** Yes charged separately...

569 **I:** Okay for delivery, 2000 rupees; and then 50-50 rupees [each time]

570 **R2:** When they [neighbours] went she didn't charge them anything

571 **R1:** No here it was taken

572 **R2:** It was taken during her time?

573 **I:** No, no. How much was it taken during this youngest one?

574 **R1:** I paid around 400 rupees this time.

575 **I:** So this time around you got the massage only for four times?

576 **R1:** Yes, only four times.

577 **I:** Which means you took the massages only for two days?

578 **R1:** Yes.

579 **I:** What about other pregnant women, how many times does the *dai* massage them?

580 Was it only for you that she massaged only for two days?

581 **R2:** Depending on how much income one has, people will be able to afford the

582 massages accordingly. Some ask for 12 days of massage, some others will say

583 continue it for 10 days.

584 **I:** What is used for the massage? Is it oil?

585 **R1:** Yes it is oil.

586 **R2:** First she'll massage with the oil then later with crushed mustard seeds...

587 **R1:** You know what mustard seeds are right?

588 **I:** Yes, yes...

589 **R1:** So they grind the mustard seeds...

590 **I:** Okay.

591 **R1:** They'll first grind the mustard seeds and then mix it with the oil and this oil will

592 be used for the massage...First the mustard seeds and then the oil is used for the

593 massages...

594 **I:** Does this alleviate the pain then?

595 **R1:** All this is never done at a hospital, here at home you're relaxed while getting all  
 596 this done.

597 **R2:** This helps to clean the stomach, and the massage flattens the tummy otherwise it  
 598 looks bloated without the massage...

599 **R1:** This is the reason...I mean they wouldn't do all this at the hospital but the *dai*  
 600 will do all this at home...

601 **I:** The *dai* seems to be taking care of a lot of things...

602 **R1:** Yes, she does a lot of things...

603 **I:** I mean when the *dai* comes over...

604 **R1:** I mean when you keep getting all the massages after giving birth, they press at  
 605 appropriate places so that all the residual impure blood inside comes out...

606 **I:** Yes, correct.

607 **R1:** She didn't give a proper massage like she usually does during this one's time  
 608 (unclear)

609 **I:** They don't do all this in the hospital?

610 **R2:** They do nothing there...

611 **R1:** During her time (pointing at the youngest child) the *dai* massages with her feet  
 612 while placing it on my stomach and back, in this way when they massage with the  
 613 feet all over the body.

614 **I:** Who does this, the *dai*?

615 **R1:** yes, the *dai*...

616 **I:** Isn't it painful?

617 **R1:** no, not at all, in fact it helps to remove all the bad blood from the body...

618 **I:** When does she give you the massage?

619 **R1:** During the day time...

620 **I:** If the delivery takes place in the evening, then when will she give the massage?

621 **R1:** Then she'll massage the next day...

622 **I:** The next day okay. Isn't that painful?

623 **R1:** No, in fact massages make your body stronger, especially when you use mustard  
 624 oil, it's good. The mind feels fresh and happy. Will they do all this at the hospital  
 625 [tell me]? They won't, it's just that you register your name there, and then give birth  
 626 and you're done. They'll just give a bath and clean the baby and leave. Now here at  
 627 home everything is taken care of...

628 **I:** You were saying something that your *khala* comes home to pray on your behalf  
 629 and the *dai* comes over prepares tea and makes you drink it. Thereafter as she said  
 630 you lie down and relax and the *khala* sits next to you and the *dai* on the other corner,  
 631 I didn't exactly understand this...

632 **R2:** See when there is extreme pain, a person sits at the back, will not able to hold  
 633 anything, and falls down. So if someone sits on one of the sides and the other one  
 634 sits at the back. And when the baby is descending downwards, she [*dai*] comes to  
 635 know about this and so she sits at the back, provide support and then gives massage  
 636 does something. There is nothing in hospital. [In the hospital, the sister] comes only  
 637 after seeing that half of the baby has come outside.

638 **I:** So, *dai* then conducts delivery properly? Doesn't she use a blade? Is it that the  
 639 umbilical cord...

640 **R1:** The umbilical cord...

641 **I:** Yes, they cut it off with a blade, right?

642 **R1:** After she cuts off the umbilical cord, she washes and cleans the baby

643 **I:** And then does she give any medicines?

644 **R1:** No.

645 **I:** Okay, she doesn't give any medicines and then for the medicines...you go to Dr  
646 Sam, isn't it?  
647 **R1:** No, I don't take any medicines.  
648 **I:** You don't take any medicines, really?  
649 **R1:** No.  
650 **I:** And what about the baby, have you given the baby vaccination?  
651 **R1:** Yes vaccination is done.  
652 **I:** Where do you go to get the injections for the baby?  
653 **R1:** People come here to our place...  
654 **I:** The doctor comes home and administers shots to the baby...or is it somebody else?  
655 **R1:** There is staff from hospital M, here at the office...  
656 **I:** Okay.  
657 **R1:** It's Kennedy office, it's that Kennedy brother  
658 **I:** Yes, yes...  
659 **R1:** There only all of them gather, even the ones who come to administer  
660 doses...they come on Sundays...  
661 **I:** So you take her over there?  
662 **R1:** Yes, she was given the injection there only. I'm scared to see when kids are  
663 given injection. That investigator no who took you to the office no was the one who  
664 administered tetanus injection to my child...  
665 **I:** Yes, yes. So you didn't get a tetanus injection for yourself after the delivery?  
666 **R1:** No, I had taken that injection.  
667 **I:** But you'd said earlier that you didn't go...when you went to the hospital at around  
668 your 8<sup>th</sup> month of pregnancy...  
669 **R1:** I have taken this injection. They had given me an injection after my delivery...  
670 **I:** Hmmm...  
671 **R1:** The next day I got the tetanus injection...  
672 **I:** For whom?  
673 **R1:** For myself...  
674 **I:** Okay for yourself, but when you were pregnant; didn't you get yourself any shot  
675 that time?  
676 **R1:** No, that time neither did I ask for it nor did anyone give it to me...  
677 **I:** And thereafter did you have any problems?  
678 **R1:** No, nothing at all...I had left everything to god's will...  
679 **I:** You didn't feel any kind of discomfort during your entire 9 months of pregnancy?  
680 **R1:** No, nothing at all happened...  
681 **I:** You didn't have to go to the hospital even once during this period?  
682 **R1:** No, not once. Why would I lie? I'm telling you the way it is, nothing had  
683 happened.  
684 **I:** Okay, but that time you told me you were scared hence I thought...and you also  
685 mentioned that people said certain things, thereafter your fear increased...I just  
686 wanted to know what made you fear (the hospital) ?  
687 (Child cries, the respondent says she's crying because she woke up from her sleep).  
688 **R1:** During her time I got the injection, now it's enough, I don't want any more kids.  
689 I have had four already, two sons and two daughters, that's enough...  
690 **I:** Hmmm...So during her time...  
691 **R1:** (Cuts in)...the real thing is that when I get pregnant I don't even come to know.  
692 Lot of people get vomiting, many feel nauseated. But for me, neither did I have  
693 vomiting nor did I feel nauseous. For me it was like, eat everything, drink

694 everything, and carry on normally. When I enter my 5<sup>th</sup> month of pregnancy that is  
695 when I realise that I'm pregnant.

696 **I:** You must be missing your periods also, isn't it?

697 **R1:** Yes, I don't get my periods at all...

698 **I:** So didn't you feel or it struck you that you must be pregnant? Because during  
699 pregnancy you miss your periods, right? So you must be realizing then that you're  
700 may be pregnant...

701 **R1:** No, once I had gone for a check-up, but I was told that I wasn't pregnant...

702 **I:** Was it during her time that you'd gone for a check-up?

703 **R1:** And my youngest child was born...

704 **I:** During her time, did you come to know that you're pregnant during your 5<sup>th</sup>  
705 month of pregnancy?

706 **R1:** Yes, during her time I got to know in the 5<sup>th</sup> month of my pregnancy that I was  
707 actually pregnant, otherwise, I never realised it sooner

708 **I:** Ok

709 **R1:** Now, see many people get vomiting or no? But I never get vomiting. So that  
710 people would come to know that a baby is to be born in this home. I would eat  
711 everything, do daily chores and carry on normally without any signs of pregnancy...

712 **I:** Okay, I just wanted to know from you, what have you heard from people that you  
713 feared (going to the hospital)? Although you told me about your fear of the blade,  
714 but as I understood it you said that the blade is used only during the first delivery,  
715 they don't use a blade for deliveries thereafter...

716 **R1:** (respondent looks confused).

717 **I:** Do they use a blade after the first delivery, for subsequent deliveries?

718 **R1:** Nodded no.

719 **I:** they don't use still you never went?

720 **R1:** I fear going there so I don't go. Everybody says that they use a blade during the  
721 first delivery, now whether they use a blade during the [delivery of] first baby or the  
722 second baby, I don't care. I don't like to go to the hospital. The home-birth happens  
723 safely and comfortably no that's it.

724 **I:** When you had your first baby through a home birth, you said that people are  
725 called to pray for you and the baby, and your first delivery was a success. Is it that  
726 you liked your home-birth experience and hence you thought of doing all the  
727 subsequent deliveries at home? And all of them were therefore born at home...

728 **R1:** Yes all of them were born healthy and the deliveries were successful. All of the  
729 babies were born the normal way. This elder one, the next one, the girl after that and  
730 this last baby girl, all of them were born through a normal delivery.

731 **I:** So you haven't seen?

732 **R1:** No, I have never been there (hospital) then how will I see?

733 **I:** Then you say you fear the blade, and the stitches but you haven't ever seen how it  
734 is done, then why the fear?

735 **R1:** Hearing creates fear. When you hear you fear. Hear this so [I] don't go. That's  
736 why I don't go. Here at home, everything happens properly, so God gives you, that's  
737 it.

738 **I:** At the time of registering your name, does the doctor tell you or describes  
739 anything?

740 **R1:** Means what?

741 **I:** I mean you told me earlier that you had registered your name at M hospital...

742 **R1:** I didn't say M hospital, during her time I went to register my name at D  
743 hospital. At M hospital, I had been there when I was carrying my eldest one.

744 **I:** Yes, that is what I meant wherever it was M or D hospital...

745 **R1:** Yes I register my name there but after that I never go back again...if it is

746 supposed to happen, it happens at home.

747 **I:** So when you register your name, during that time does the doctor give you any

748 information regarding the baby or regarding the pregnancy or things like how you

749 should live during your pregnancy period, which position should you sleep or what

750 diet should you follow all this...do you get this kind of information?

751 **R1:** No, absolutely nothing.

752 **I:** They don't give you any information?

753 **R1:** But I never go there so...

754 **I:** no, but you told me just now that you at least go and register your name, didn't

755 you get any information at that particular time?

756 **R1:** No, they don't say anything or give any kind of information.

757 **I:** Did you go to the hospital during her time?

758 **R1:** Yes, I went but they refused to register me saying that it's too late now...

759 **I:** They didn't register your name because they said that you were already in your 9<sup>th</sup>

760 month of pregnancy?

761 **R1:** Yes

762 **I:** But why did they do that, didn't you ask them?

763 **R1:** Who would go and argue with them, they're very rude, foul-mouthed people,

764 they treat us like dogs and shoo us away...

765 **I:** The female staff there, is it?

766 **R1:** Then what?

767 **I:** Then this...

768 (R shouts at the child...as he runs outside from home)

769 **I:** Then during her time where did you say that you had registered your name? You

770 had been there in your 9<sup>th</sup> month of pregnancy, where was it?

771 **R1:** In M hospital

772 **I:** You went to M hospital...and they sent you back just like that...

773 **R1:** Hmmmm...

774 **I:** Isn't it?

775 **R1:** Yes.

776 **I:** Okay. I was just thinking what happened...

777 **R1:** (laughs)

778 **I:** I kept assuming that you don't go there because it's far away from your home or

779 because there are male doctors there...

780 **R1:** M hospital is pretty close by, it isn't far...

781 **I:** Or maybe because...

782 **R2:** Since it's so close, wouldn't you go?

783 **R1:** No, still I wouldn't go.

784 **R2:** (repeats) no, still I wouldn't go.

785 **I:** So basically you don't like going there, is it only because of the fear of blade or

786 are there any other reasons as well?

787 **R1:** Nothing else (laughs)

788 **R2:** (shouts) she doesn't like anything over there, it's not just the blade.

789 **R1:** I don't like anything at hospital M.

790 **I:** You mean at hospital M?

791 (R calls another woman from the neighbourhood)

792 **I:** You had been to register your name at hospital D as well, isn't it?

793 **R1:** What?



794 **I:** You had been to register your name at hospital D as well, isn't it?  
795 **R1:** Yes.  
796 **I:** So you're scared of the hospital itself?  
797 **R1:** I ran away from there out of fear and came home (laughs)  
798 **I:** Why do you fear going to the hospital?  
799 **R1:** I just fled from there, I don't like going to the hospitals I'm too scared of them.  
800 I'm scared of deliveries as well.  
801 **I:** You fear the use of blade, but what scares you in a hospital?  
802 **R2:** Just too scared.  
803 **I:** But why?  
804 **R1:** I don't know exactly why, I'm really just too scared of it...  
805 **I:** Are you scared of the hospital too? Tell me why are you scared of it?  
806 **R1:** I really don't know why I'm scared, but I am scared.  
807 **I:** Do you fear it because everything there looks new and big or is it because there  
808 are so many people there at a time...or is it something in particular that you're scared  
809 of...?  
810 **R1:** This is what exactly even I don't know, so what will I tell you?  
811 (R2 asks the R1 to straight forwardly say it to I that she has never been to a hospital  
812 and therefore knows nothing about it)  
813 **R1:** Why should I say that, I had been there during her time, but I ran away from  
814 there and came home. During her time my mother had accompanied me. After  
815 registered my name, I bothered everyone by running away from there.  
816 (I, couldn't concentrate because of the high volume of the TV).  
817 **I:** Sorry, I didn't understand...  
818 **R1:** What?  
819 **I:** I didn't understand...  
820 **R1:** I mean when I registered my name, my delivery time had come closer and I  
821 started to have labour pains even then my mother came and took me away from  
822 there, her grandmother came and took me home.  
823 **R2:** My mother beat me up several times...and she took me home  
824 **I:** Please allow her to talk...  
825 **R1:** (laughs)  
826 **R2:** How many times?  
827 **I:** Allow her to speak...  
828 **R2:** You know what you should do, close that door behind you and come inside and  
829 then talk...  
830 **I:** Now you go ahead and speak...  
831 **R1:** (laughs)  
832 **I:** When you went to that hospital, what happened there, what did the maternal  
833 grandmother say?  
834 **R1:** She said don't deliver at home, go to a hospital, the facilities there are good...[I]  
835 mean the impure blood gets washed out  
836 **I:** At home?  
837 **R1:** No, at the hospital, like they say there is all impure blood all around...  
838 **I:** Hmmm...  
839 **R1:** So then everything gets cleaned up there...  
840 **I:** Hmmm...  
841 **R1:** That is why I said I don't want to go there at the hospital, so I delivered at home  
842 only...  
843 **I:** Her [the child's] grandmother was asking you to go to the hospital but you...

844 **R1:** Hmmm...she took me there. I fled and returned home.  
845 **I:** Okay, but what did you see there that you came running home?  
846 **R1:** That is what surprises me...  
847 **I:** You don't know it yourself why you ran away from there...  
848 **R1:** Hmmm...  
849 **I:** You got nervous?  
850 **R1:** Yes I was really very scared...  
851 **I:** Scared of whom?  
852 **R1:** God only knows who I saw and got scared, I got confused and scared. I don't to  
853 go back to the hospital.  
854 **I:** Tell me something about it, sometimes we think of something or imagine  
855 something that scares us, was there anything in particular that you were scared of?  
856 **R1:** That is precisely what even I don't know. I don't know the reason of my fear; I  
857 have never given birth at the hospital, so how would I know. I had just registered my  
858 name there, got an injection and returned home.  
859 **I:** Are you scared of the doctor? Do you get scared when you see a doctor? You  
860 already told me that you don't like it when you see male doctors, but is it okay if a  
861 female doctor treats you? Is a female doctor fine?  
862 **R1:** Even then, a female doctor will also use blades and scissors...  
863 **I:** So you're scared of surgical instruments, is it?  
864 **R1:** When I see all of those things I shudder at their sight, and I get very tensed and  
865 stressed after that.  
866 **I:** This is what I'm trying to tell you as well that the other lady also said that looking  
867 at the big machines and surgical instruments instils fear in her. And you're saying  
868 that you don't know what you're fearful of, you just mentioned about the scissors,  
869 are you scared of them? Or is it the injection that scares you?  
870 **R1:** Nodded no.  
871 **I:** You don't know?  
872 **R1:** My delivery didn't take place there, I never gave birth there, how would I  
873 know?  
874 **I:** Earlier you had said that you fled the place and came home, is this that you saw  
875 and came home running?  
876 **R1:** Only God would know why I ran away from that place like that...  
877 **R2:** She's a bit crazy; she hasn't seen anything there and just ran away from that  
878 place.  
879 **R1:** I hadn't really seen anything there, I just got nervous and scared...  
880 **I:** Yes, that's what I'm talking about...  
881 **R1:** And nothing else...  
882 **I:** That other lady had told me that she also gets nervous and scared upon seeing the  
883 hospital, the big machines, does that scare you too? These big machines at the  
884 hospital, do they scare you?  
885 **R1:** Yes, he placed a huge machine right next to my head, I said nothing (joining  
886 both her hands together making a loud sound) I quickly wore my salwar (pants) and  
887 got away from that place...  
888 **I:** Okay, so they asked you that...  
889 **R1:** Hmmm...  
890 **I:** Asked you to lie down?  
891 **R1:** I said, "I won't lie down, I'm going away from here!" My mother's finger prints  
892 as a proof of signature were put down on all necessary forms everywhere, and they  
893 took me inside...

894 **I:** Okay...

895 **R1:** I said, "I don't want to stay here. I'm going home, I don't want to deliver here...

896 I'll deliver at home"...

897 **I:** What had they got with them?

898 **R1:** They had got some machine with them...I don't know what machine it was...

899 **I:** How did the machine look?

900 **R1:** It was a huge machine. I didn't even see it properly...

901 **I:** Was it being strapped here? (I was showing her how the cuff of BP measuring

902 instrument is strapped onto the arms).

903 **R1:** I didn't even see, they got it with them and kept it, I never saw it...

904 **I:** Was it really big?

905 **R1:** It was this big (shows the length of a full hand)...

906 **I:** Okay, okay, did you see that machine properly?

907 **R1:** I saw it and I was scared...

908 **I:** Is that why you ran away from there?

909 **R1:** Yes and nothing else...

910 **I:** Okay, this is what I was precisely asking you, so it is the injection that scared you,

911 okay fine. And this is the reason why you are scared of the hospital.

912 **R1:** I'm scared of the hospital that is the first thing I said...

913 **I:** And thereafter they make use of the blade, that also scared you off and even the

914 machine was a part of your fear...

915 **R2:** You're scared of people, you're scared of animals, and then you're scared of

916 blades. And you're scared of giving birth too...

917 **R1 to R2:** But what is the problem if I give birth at home?

918 **I:** Since you gave birth at home that is why...

919 **R1:** My kids were all born the normal way...

920 **I:** At home you don't get scared at all?

921 **R1:** No.

922 **I:** Why aren't you scared at home?

923 **R1:** What happens at home is that one can easily walk around whenever one wants

924 to. If the pain is unbearable then you can sit down and relax.

925 **I:** Yes...

926 **R1:** Right? Then the pain subsides a bit...

927 **I:** Hmmm...

928 **R1:** Then one can again keep moving around a bit.

929 **I:** Okay, this is why you like it at home...

930 **R1:** Now I don't want any more children, now it's enough. I've had two sons and

931 two daughters that's more than enough now.

932 (The other woman yells at the respondent saying that it is fine if she doesn't want

933 another child after this but there is no need to say all this to I) (The respondent

934 ignored her and instead called out to her child who was trying to go out of the

935 house).

936 **I:** Okay, now I will tell you whatever you have told me until now. Please correct me

937 if I am wrong.

938 **R1:** Okay, begin...

939 **I:** So far all that we talked and discussed in that you said that during the first delivery

940 you saw all those things ran away from there and returned home. Since then you

941 have always feared the hospitals. Thereafter you had all your births at home

942 normally. Your *khala* (mother's elder sister) came over and blessed you and prayed

943 for your successful and safe delivery. This all nice things happen at home so you  
 944 delivered the rest of the children at home only. Am I right?  
 945 **R1:** Nodded yes.  
 946 **I:** And you're scared of the blade, male doctors and the hospital, am I right?  
 947 **R1:** Nodded yes.  
 948 **I:** And one more thing that you said was that at hospital M, the helper staff didn't  
 949 talk to you politely, they just shoo you away...  
 950 **R1:** Yes, they don't talk politely at all...  
 951 **I:** In all of them, you don't like this one. And when your neighbour's had a delivery  
 952 [at hospital] it just didn't went right.  
 953 **R1:** Nodded yes.  
 954 **R2:** Now look at her, she doesn't get massages anymore...  
 955 **I:** You get a good massage. The newborn is washed and cleaned properly and is then  
 956 handed over. The *dai* does not use any blades. Hence you...  
 957 **R1:** In the hospital, when it's the first delivery they make use of a blade...  
 958 **I:** So the *dai* doesn't use a blade even if it's the first delivery?  
 959 **R1:** Why wouldn't she? Of course she uses a blade...  
 960 **R2:** *Dai* doesn't use a blade even at the time of the first delivery.  
 961 **R1:** The helper staff makes use of a blade at the time of the first delivery...  
 962 **I:** No, no I'm talking about the *dai*, not the *baai* [helpers]...  
 963 **R1:** *Dai*'s don't use a blade...  
 964 **I:** I'm referring to a *dai*. *Dai*'s don't use a blade, am I right?  
 965 **R1:** Yes, they don't.  
 966 **I:** That is why you prefer giving birth at home with the assistance of the *dai*, am I  
 967 right?  
 968 **R1:** The way doctors and nurses give the injection for [inducing] labour pain  
 969 **I:** Hmm...  
 970 **R1:** So that the baby is quickly born...  
 971 **I:** Hmm...  
 972 **R1:** It's the same with the *dais*. I have never had an injection [for inducing the  
 973 labour pain] during any of my deliveries. It was during her time (youngest child) that  
 974 I was given the injection during my delivery.  
 975 **I:** Who gave you that injection, was it the *dai*?  
 976 **R1:** Yes, I was given the shot, a little effect was because of the injection and the rest  
 977 was because of a hard push from my side made the delivery of the child possible.  
 978 **I:** Okay...  
 979 **R1:** They (*dais*) also have enough knowledge about these things contrary to the  
 980 perceptions of them...  
 981 **I:** They perform everything properly and administer the injections as well?  
 982 **R1:** Everything, everything [perform properly]...  
 983 **I:** That is what I had asked you earlier, what are all the things that the *dai* takes care  
 984 of?  
 985 **R1:** You know how it is there (at the hospital), the *baai*'s (helpers) keep yelling at  
 986 the patients and are very rude to us. They say offensive things like you only like to  
 987 sleep with your man. All you like to do is have [sex all the time with your man]. All  
 988 these things are never uttered by the *dais* in home-birth scenario.  
 989 **I:** The *dais* talk with you politely and treat you kindly?  
 990 **R1:** Yes.

991 **I:** Correct, and I told you how the *dai* performs the delivery and how she conducts  
 992 everything thereafter. So you like all this and prefer it more and hence all your  
 993 children have been born at home, right?  
 994 **R1:** Yes  
 995 **I:** Do you want to tell me anything else?  
 996 **R1:** No, nothing more...didn't I told you that day, when I was taken to the office...  
 997 **I:** You had mentioned earlier that you've heard things but haven't gone and seen  
 998 them. And later you mentioned how you saw the machine and ran off from there.  
 999 Did you see the machine?  
 1000 **R1:** Yes.  
 1001 **I:** Okay now I'm informing you that I'm a doctor by qualification and hence if you  
 1002 have anything to ask me you can please do so. Do you want to ask anything to the  
 1003 people working at SNEHA? I work at SNEHA too. Do you want to ask me  
 1004 something, could be about anything? You had asked me some questions at the start  
 1005 to which I said that I will answer them later, ask me those questions if you have any.  
 1006 Ask me whatever you wish to...  
 1007 **R1:** What... (inaudible at 48:36)  
 1008 **I:** What do you mean by that?  
 1009 **R1:** I mean what is to be done now?  
 1010 **I:** No, nothing, just in case if you have any queries or doubt regarding anything you  
 1011 can ask me.  
 1012 **R1:** What else should I ask you? You wanted information from me, you asked me  
 1013 questions and I answered them and what else...  
 1014 **I:** Do you want to ask anything related to health issues or anything else?  
 1015 **R1:** What about health, what should I ask? Now it's just that I have a lot of lower  
 1016 back pain lately...  
 1017 **I:** Okay.  
 1018 (The respondent asked me about her health problems and I answered her questions. I  
 1019 gave few suggestions on the changes to be done in her diet and sleeping patterns).  
 1020 **I:** I'll right you a prescription now, and I thank you for the time you spared for me,  
 1021 almost an hour. I thank you from the bottom of my heart for giving me such valuable  
 1022 information.

**END OF TRANSCRIPT**

## SUMMARY

The respondent is a 30 year old Muslim woman who gave birth to all her four children at home. She does not like to go to any hospital. Earlier in the FGD with the women who delivered at home, this respondent has told very clearly that she is scared of the hospital and hence never visited at the time of her delivery. So this interview with her explored in detail why she is scared of the hospital. This interview actually served as a good example of why a woman prefers a home delivery over a hospital delivery.

The respondent herself was not clear about her fears. She always said that only God knows why she is scared of the hospital and why she ran away. After she came back from the hospital, she happened to deliver at home which was a normal delivery. Her mother's sister came and prayed for her to deliver quickly and safely. The *dai* who conducts the delivery does it well. She prepares the tea and gives her a drink, which actually quickens the delivery process. During the delivery the *dai* supports her emotionally as well as physically. She also gives injection sometimes to quicken the delivery process. She gives a massage on her abdomen and back so that the abdomen gets back to its original shape soon and the impure blood is removed from the body, as per the respondent's understanding. At the time of delivery, she can move around at home in between episodes of labour pain. She thinks that the delivery happens successfully at home. Everything that happens at the hospital also happens at home, but with more comfort and blessings. So, there is no need to go to hospital, everything happens at one's own place.

When the first delivery happened with ease and comfort, she thought of delivering all of her children at home. The thing she doesn't like about the hospital is that the doctor is a male. She feels shy as well as scared of the male doctor. Later she also says that she is scared of the female doctor. Then the staff, the helper, abuses her, uses bad language and shoos her away. When she went to hospital for the delivery of the youngest child, the staff didn't register her name because she went to register in the eighth month. This demotivated her from going to the hospital. She has seen some kind of machine in the hospital. She wonders what it might be for and it makes her scared. She has heard from the people that a blade is used for the delivery of the

first child. The staff do not look after you at the time of delivery and come only when the baby's head comes out. This has helped her to develop a fear of the hospital.

Socially and economically, she never had a problem with money, since the government hospital generally takes 500 rupees for the delivery of the third baby onwards. The respondent pays almost 2000 and 400 rupees for the delivery to the *dai* for conducting the delivery. She prefers to pay a *dai* instead of paying at the hospital. She preferred to go to a particular doctor for general treatment to Dr. Sam who is Muslim, although it is not clear, whether she goes to that doctor because he belongs to the same religion.

This interview explains why some women like to deliver at home and not at hospital. The respondent delivers comfortably at home, with the inclusion of blessings from the elder person of the family and the good performance of *dai* in conducting the delivery like giving emotional and physical support, giving tea and massage, in addition to cleaning and bathing of the baby. The respondent did not like the rude behaviour of the hospital staff, has a fear of instruments like blade used in the sensitive part of the body. Has a fear of the doctor and hospitals in general.

## Appendix L. Example of a higher quality transcript

ID number	nbddedprmar0003
Site	SNEHA
Type of data collection	Interview
Phase of data collection	B
Date of data collection (English YYMMDD)	13/08/06
Pseudonym for place name	Argentina
Gender of participant	Female
Sampling criteria	Hindu, SES least poor, high education, delivered in private facility
Data collector name	Ketaki
Observer	Glyn
Language of data collection	Marathi
Number of participants	1
Different respondent identity*	See Table below

**Interview No:** nbddedprmar0003

**Interview type:** Interview

**Date:** 6th August, 2013

**Scheduled Start Time:** missing

**Scheduled Duration:** 30 minutes

**Actual Start Time:** missing

**Actual End Time:** missing

**Actual duration:** 47.16 minutes

**Location:** Argentina

**Participants:** Interviewer (I), Respondent (R).



<b>Name</b>	R
<b>Age</b>	30
<b>Education</b>	Post Graduate
<b>Religion</b>	Hindu
<b>Duration of stay (in years)</b>	3
<b>Parity</b>	1
<b>Age of the youngest</b>	1½ years
<b>Currently pregnant</b>	No
<b>Place of ANC and delivery of children</b>	ANC: Private GP (Mumbai) and Hospital DA (Outside Mumbai) Delivery: Hospital DA (Outside Mumbai)

### Observations

I, G and S reached the SNEHA Centre at Argentina at the designated time in the afternoon. The centre is situated in one of the buildings, which have been erected under the Slum Rehabilitation Act. It was the first time me and S were to collect data from the Argentinian SNEHA Centre, the centre's reputation was that of the best maintained centre among the rest, the people to whom this centre catered were known to be of a higher socio-economic status and were primarily Hindus. We located the centre easily and met the investigators inside. There was some confusion among the number of women to be interviewed and the venue for the interview. Eventually it was decided that we would interview 2 women each, 4 in total in the centre itself.

The respondent (R) for this interview was my first respondent for the day. She was a Hindu woman who had delivered in a private facility, she belonged to the least poor socio-economic status and had a Master's degree, among all the respondents she was the only one who could understand and speak English. R came in for the interview with her one and a half year young baby and her niece, the baby often cried during the interview and the niece wandered around the centre under the watchful eye of the investigators. I and the respondent sat in one corner of the room accompanied by I2,

because R spoke some English I2 could have direct conversations with her and required little help from me as not much translation was required. This is the only interview which has been conducted in two languages – Marathi and English.

R had accessed ANC and had delivered in a private hospital outside Mumbai and hence she did not fit the regular criteria of our sampling. Nonetheless I and I2 decided to interview her because we were interested in understanding her reasons for travelling to another city for her ANC and delivery. The respondent was very keen to talk to us and she was patient even when questions were repeated because I2 often missed out on conversations conducted in Marathi. Unlike the majority of respondents we have had she was truly glad and enthusiastic to share her information and thoughts with us. This could be because her relatively higher level of education meant that she could understand the purpose of the study and could comprehend the questions; she often showed interest in what we did and not only did she answer our questions patiently but she also asked us questions in return.

At the end of the interview the respondent thanked us for showing an interest in the health care of women from her area, she had always thought that people in her area don't have proper access to health care and she took us conducting our research there as an indication that there might be some development of health care facilities in the future. This was the first time that a respondent had thanked us and I felt touched that she had thought about it.

1 (00.00-00.54 I notes down R's details.)  
2 **I:** Which hospital did you deliver in?  
3 **R:** I delivered in DA hospital [private hospital outside Mumbai].  
4 **I:** Where is DA?  
5 **R:** In Greenland.  
6 **I:** Okay.  
7 **R:** Syria.  
8 **I:** And where did you go for check-ups [ANC]?  
9 **R:** Earlier there used to be a doctor here, I used to go to him, he was called Geller  
10 [private clinic in Mumbai].  
11 **I:** Geller?  
12 **R:** Yes.  
13 **I:** Is he a private doctor?  
14 **R:** Yes, I mean she is a gynaec [gynaecologist].  
15 **I:** She is a gynaec?  
16 **R:** Yes. She has a clinic here and [she also has a clinic] somewhere else. [But] all my  
17 treatment has taken place there [in Canada], he is the main gynec there. I used to go  
18 every 2 months there [to Canada] for check-ups.  
19 **I:** So this [hospital] DA...is it private?  
20 **R:** Yes, that is private.  
21 **I:** And you used to go there every 2 months for check-ups?  
22 **R:** Yes.  
23 **I:** And when did you go to Dr. Geller here?  
24 **R:** Here I used to go every month, if there was a problem during the start [of the  
25 pregnancy] I used to come here only, the first 2 months I used to come here only,  
26 and later my mother took me there.  
27 **I:** Then Dr. Geller and Dr. –  
28 **R:** (inaudible 02.03)  
29 **I:** But he is also private?  
30 **R:** Yes, private.  
31 (I discusses R's case with I2. Although R has had ANC and has delivered outside  
32 Mumbai, I and I2 decide to go ahead with the interview.)  
33 **I:** Normally when someone at home where do you or your family members go?  
34 **R:** Her [niece's] mother's delivery has happened here only in that EA hospital, it's a  
35 charity hospital. So she delivered there and there is this one there, that one is a  
36 private hospital, we go there for small things [ailments].  
37 **I:** Was that during the pregnancy?  
38 **R:** Yes.  
39 **I:** And what about the times when you weren't pregnant...when the baby is sick or  
40 when your husband is ill...where do you go then?  
41 **R:** Here there is someone called Dr. Mosbey. Dr. Mosbey.  
42 **I:** Mosbey?  
43 **R:** Yes.  
44 **I:** Okay, so he is private, then?  
45 **R:** He is also private.  
46 **I:** Okay.  
47 **R:** We go her to private hospitals, and I went to government hospitals only for the  
48 vaccinations when I was pregnant. [I] went to government only for the injections  
49 otherwise we get treatment in private only.  
50 **I:** Where did you go for these injections?

51 **R:** Yes, those vaccinations are then no...for every month, for 2 months, 3 months, 4  
52 months, for that used to go to the government hospital which is just here.  
53 **I:** That M hospital which is nearby?  
54 **R:** Yes.  
55 **I:** Why did you go there for vaccinations?  
56 **R:** I did not know much about this place and during the start my sister-in-law had  
57 delivered there only...and the other injections which are not given there [at hospital  
58 M] or which are costly I take those in private. Those injections which reasonable  
59 [reasonably priced] those reasonable ones are given in hospital M, (switches to  
60 English) around 200/-, they give only that much, above 500/-, above 1000/-  
61 (switches to Marathi) they don't give [in hospital M]. Then have to go to private for  
62 that.  
63 **I:** Do you know what are those vaccinations for?  
64 **R:** For *govar* [chicken pox?], for *mendu jwar*, for hepatitis, all that.  
65 **I:** Do you get the other things [other than vaccinations] at private?  
66 **R:** Yes.  
67 **I:** So why do you go to hospital M for vaccinations?  
68 **R:** Because here these people had given [sister-in-law had gone there for her ANC],  
69 his [my husband's] brother told us to go there so we went, and there they gave  
70 [injections].  
71 **I:** So is she [the person you are talking about] her [your niece's] mother?  
72 **R:** Yes.  
73 **I:** So you used to go with her [to the hospital]?  
74 **R:** Yes, I mean she had taken me along with her, he [her baby?] was young that is  
75 why (meaning unclear). Before that I used to stay in Canada, because of that I just  
76 knew things about just Canada. I did not have much information about here, so I  
77 used to go with her, that's how I got injections there. That's how I got injection  
78 there.  
79 **I:** So do you mean she wasn't pregnant then and that she used to come for you?  
80 **R:** No, she is pregnant now, she gave birth to a girl, it's not even been a month  
81 [since the delivery].  
82 **I:** So did she [her sister-in-law] have experience [about hospital M] because of  
83 [giving birth to] her (referring to R's niece)?  
84 **R:** Yes, that is why she told us [about the hospital].  
85 **I:** So you used to go [to a doctor] there at Greenland, right?  
86 **R:** Yes.  
87 **I:** Before that you went to Geller [doctor in Mumbai]?  
88 **R:** Yes.  
89 **I:** When did you go to him?  
90 **R:** In the first month, I mean when I was one and a half month into my pregnancy I  
91 had gone there to get my pregnancy tested. I had checked at home but I wanted to  
92 get a doctor's opinion. So I started [going there] from then on. I took medicines  
93 prescribed by him for 2-3 months, after that I went to the doctor at Greenland. My  
94 brother's wife had already delivered 2 babies there, so we had faith (her word) on the  
95 doctor, that is why we used to go there.  
96 **I:** How many times did you go to Dr. Geller?  
97 **R:** I went there 2-3 times, I didn't go many times.  
98 **I:** And then you went to Greenland?  
99 **R:** Yes.  
100 **I:** You said you went there every 2 months, right?

101 **R:** Yes, yes, yes. Anyway I used to go home every 2-3 months, I used to go every 2-  
102 3 months.

103 **I:** So why go so far away? You talked about faith-

104 **R:** No, I wanted my delivery to happen there and only there, thus I wanted the  
105 regular treatment [ANC] from the same doctor.

106 **I:** Why did you want to deliver only there?

107 **R:** Over there, at my mother's place. In our community the woman delivers [for the  
108 first time] at her mother's place, right? Because of that reason and because of the  
109 reason that in our family everyone delivers there, at the same doctor.

110 (S's respondent refuses to sit with her, she wants to sit next to R. The investigators  
111 convince her to sit with S. 06.54 – 08.01.)

112 **I:** Sorry, you were telling me something to do with delivering there, right?

113 (R's niece who has accompanied her tries to distract her, R asks her not to do so.)

114 **I2:** (to R) Do you speak English?

115 **R:** Yeah, I speak.

116 **I2:** So can I ask you these questions?

117 **R:** Yeah, yeah, definitely.

118 (I2 jokes about not needing I anymore for the interview. I and R laugh.)

119 **I:** (to I2) She was just telling me why she travels all the way. (To R) Can I speak in  
120 English? Is that fine with you?

121 **R:** Talk in any language you want, I don't mind.

122 **I2:** So you are okay with English?

123 **R:** Yeah, yeah. Yes I can.

124 **I2:** Thank you

125 **I:** So because you wanted to deliver first time at your mother's place?

126 **R:** Yes.

127 **I:** Any other reasons that you had t-

128 **R:** No, no other reasons.

129 **I:** Earlier you said something about trust, that there is trust-

130 **R:** No, I meant...there is this one doctor here where my treatment was going on so I  
131 did not get cured over there with his treatment, actually I am a patient of  
132 convulsions.

133 **I:** A patient of what?

134 **R:** Convulsions.

135 **I:** Okay.

136 **R:** When her [her baby] was 6 months old I had an *akdi*. My hands and feet had  
137 twisted completely, my eyes had turned white, my tongue had rolled inside, so at that  
138 time I got a treatment from here and there was relief for some days, a year passed  
139 and then again I got one of those attacks. Because of this I don't have faith in these  
140 doctors here, I don't [trust them] easily.

141 **I:** So do you trust the doctor in Greenland?

142 **R:** Yes.

143 **I:** So these things that happened to you did they happen during his bir-

144 **R:** They happened later.

145 **I:** Later?

146 **R:** And even during his [her son's] time the doctors here told me that it would be a  
147 cesarean (asks her niece to keep quiet) so he told me that I would have to get a  
148 cesarean done here but there I had a forceps delivery, a normal one.

149 **I:** You had a normal delivery there?

150 **R:** (nods yes).

151 **I:** Okay. So you just mentioned that you did not have faith [in doctors in  
 152 Mumbai]...so that must have happened later on [after you chose the doctor], right?  
 153 **R:** No, I had also taken treatment here at the start, right? Even then I did not feel  
 154 right, even my husband has some stomach problems, so he had a lot of treatments  
 155 here but he did not find any difference [in his condition].  
 156 **I:** Where did he used to go? To Canada?  
 157 **R:** No, my husband has been staying here since a long time, so I took him to this  
 158 doctor called Dr. Sarah, she is a gynaecologist in Dublin, no in Norway, so he did  
 159 not find any difference even when he went to that madam. Moreover I don't know  
 160 many hospitals here so I get even my baby treated there [at Greenland] from the  
 161 doctor there, the one who treats children, I get a prescription from him and give him  
 162 those medicines.  
 163 **I:** So you get his medicines too from Greenland?  
 164 **R:** Yes.  
 165 **I:** (to I2) [She says], "I don't have faith in doctors in Bombay.")  
 166 **I:** Did you stay in Canada before this?  
 167 **R:** Yes.  
 168 **I:** Did you feel the same in Canada?  
 169 **R:** No, no. I had a doctor in Canada, he was really good and I used to go only to him  
 170 before my marriage.  
 171 **I:** And then you came her to Mumbai after marriage?  
 172 **R:** Yes, I shifted here to Mumbai.  
 173 **I:** And the doctors in Mumbai according to you...?  
 174 **R:** No, their treatment doesn't agree with me. I mean specifically the doctors  
 175 here...her in Argentina [R's locality]. The doctors in Argentina.  
 176 **I:** What about the ones outside Argentina?  
 177 **R:** Yes, there is this one doctor called Sarah, her medicines have proper effect on  
 178 me, but his [referring to her baby] father doesn't feel a difference; I mean they the  
 179 medicines prescribed by her don't suit him. He doesn't feel a difference, it causes  
 180 him problems.  
 181 **I:** So the vaccinations you were talking about-  
 182 **R:** Those [I take] only from government hospitals.  
 183 **I:** From government hospitals?  
 184 **R:** Yes.  
 185 **(I:** (to I2) She just took...her ANC, her vaccination shots from [hospital] M. Because  
 186 she (unclear word, 11.20) ... hospitals in Bombay, she has migrated.  
 187 **I:** (to R) Then-  
 188 **I2:** Should...can I ask a question?  
 189 **I:** Yeah.  
 190 **I2:** (to I) You might have asked it. (To R) Like you say faith, having faith in a  
 191 doctor...what do you mean [by] faith? [Do] you mean faith in their ability to be a  
 192 good doctor or faith that they'd be a nice person to you? What does faith mean?  
 193 **R:** (in English) Not a good doctor because we...(switches to Marathi) I mean...the  
 194 problems that I have, they should be cured by that doctor...if there is no difference  
 195 [after the treatment] then what is the use?  
 196 **I:** (to I2) Whatever problems she and her husband have had and they have gone to  
 197 these doctors, they have not received proper treatment enough to cure it altogether.  
 198 **I2:** So the faith in the doctor (inaudible 12.02, R's niece shouts in the recorder.)  
 199 **I:** Cure-  
 200 **R:** Treatment.

201 **I2:** Treatment?  
202 **R:** Yeah.  
203 **I:** So the other doctors... [for instance] the Canada one and the Greenland, the Syria  
204 one, according to her they give her better-  
205 **R:** (in English) -Better results.  
206 **I2:** Better results?  
207 **R:** Yeah.  
208 **I:** So there is something I want to ask you in general, okay? So...some say that if  
209 people have such and such amount of money they go to private or if they have less  
210 money they go to public. But we talk to women often about this so we have seen that  
211 there are many women who don't have money and yet go to private, okay? So why  
212 do you think this happens? Is there some reason that-  
213 **R:** Look, whatever I have seen about government hospitals that I have seen when I  
214 went there for vaccinations, whatever [infrastructure?] they have is not proper (her  
215 word), there is no cleanliness and the way they treat [not medical treatment] us, that  
216 is not good, those people tend to avoid [patients] completely, they do because they  
217 have to, they just push around in government hospitals.  
218 (R's niece has been making buzzing sounds into the recorder throughout.)  
219 **I:** Okay. What do you mean by treatment?  
220 **R:** The way they deal with us is not proper, I mean regarding [telling us] what to do,  
221 how to stand in the line, do this, I mean it should be proper...it [the hospital] is near  
222 us, what do we go there for? So they don't have any consideration for that and they  
223 just want to push us around [get done with it] to get vaccinations, [according to  
224 them] it should get done as soon as possible so that they are free. That's how they  
225 work. I said whatever I felt about here...about hospital M.  
226 **I:** So how does it make a difference to you when you go to that doctor [in  
227 Greenland]? What do they give you there?  
228 **R:** No, the issue is that in private I mean...the doctor gives us some attention, that's  
229 it...you get proper this [treatment] and-  
230 (R's baby becomes cranky and wants to leave, R tries to placate him. I gives him a  
231 pen and paper to play with.)  
232 **I:** When you say treatment do you mean medical treatment or the way they interact  
233 with you?  
234 **R:** Both, there is a lot of difference regarding that [treatment] in government and  
235 private hospitals.  
236 **I:** Can you tell us what the difference is?  
237 **R:** Here in private we pay them so obviously (her word) they are for sure going to  
238 give you good treatment, because of that there is an effect. Then there is this one Dr.  
239 Phil whom we make a payment to but his fee is really low, it is Rs. 35 (child  
240 screams, unclear 14.52) to get a test done. But...  
241 **I:** In private?  
242 **R:** Yes, here [in private].  
243 **I:** 35?  
244 **R:** He takes Rs. 35 just to check but whatever medicines and all which he gives all  
245 of those are effective (her word). And I feel the difference within 2 days, he had  
246 given me medicines too and I felt better within 2 days.  
247 **I:** So you don't find it effective in government?  
248 **R:** We don't go to government for check-up at all. We just go to private.  
249 **I:** What must be your approximate monthly income?  
250 **R:** Mine?

251 **I:** Household's? Do you work somewhere?  
 252 **R:** Currently I am not working, my child is still small that's why, he [husband] earns  
 253 10 thousand per month.  
 254 **I:** Ten thousand monthly income?  
 255 **R:** Yes.  
 256 **I:** So within that...I mean who bore the expenses for the private hospital?" the one in  
 257 Greenland?  
 258 **R:** That my mother and father spent.  
 259 **I:** And when you went to Greenland I am assuming you went by train?  
 260 **R:** Yes.  
 261 **I:** And the expense for the tickets and all?  
 262 **R:** My husband used to spend for one way ticket and the other way my father used to  
 263 buy.  
 264 **I:** Okay, and the doctor's expenses-  
 265 **R:** Huh?  
 266 **I:** The doctor's expenses?  
 267 **R:** That my father used to handle.  
 268 **I:** Okay.  
 269 **R:** All of the expense.  
 270 **I:** What was the expense for the delivery?  
 271 **R:** The charges for the delivery were seven thousand.  
 272 **I:** Seven thousand?  
 273 **R:** Yes, and the [other] medical expense was three thousand, because of that all of it  
 274 got done within 13 thousand.  
 275 **I:** All of that then-  
 276 **R:** Yes, my father bore it all.  
 277 **I:** (to I2) the income is ten thousand rupees, the expenses for the delivery were  
 278 incurred by the parents and...travelling one way was by the husband and one way by  
 279 the-  
 280 **R:** (in English) Return ticket.  
 281 **I2:** How far is it from here?  
 282 **R:** (in English) One night, 12 hours.  
 283 **I2:** One night...by train?  
 284 **R:** (in English) 12 hours.  
 285 **I2:** And was that specifically for your delivery? You went there-  
 286 **R:** Yeah.  
 287 **I2:** -you went only for delivery?  
 288 **R:** (in English) No, no, my parents was [were] there.  
 289 **I2:** Yeah, but I mean...  
 290 **I:** She went for check-ups as well.  
 291 **R:** (in English) Yeah, for check-ups. Every 2 months.  
 292 **I2:** Oh for check-up yeah, so you have had no check-ups here? No antenatal ca-  
 293 **R:** (in English) No, only 2-3 times.  
 294 **I2:** And where was that, in...which...hospital...here?  
 295 **R:** Private hospital ummm...  
 296 **I:** Gynac [gynaecologist].  
 297 **R:** Yes, yes.  
 298 **I2:** Close to here?  
 299 **R:** Yeah, yeah.  
 300 **I:** The hospital there who selected it? The one in Greenland?



301 **R:** The...my sister-in-law's first delivery took place there, her parents too stay there,  
 302 so her parents took responsibility for her first delivery and they got it done there and  
 303 my sister-in-law has 2-3 sisters, even their deliveries took place there. So that doctor  
 304 is very famous, I mean people who stay really far away come to see him. That's why  
 305 everyone has more this [confidence? trust? faith?] in that doctor. Because of this my  
 306 brother's [son] was born there, when his wife got pregnant for the second time we  
 307 got her delivery done at the same place despite the fact that they stayed in Nebraska.  
 308 **I:** Nebraska?  
 309 **R:** Yes, (in English) Nebraska city in Darfur [central state in India].  
 310 **I:** (to I2) they have so much trust in the doctor that her sister-in-law was pregnant in  
 311 Darfur, she came all the way to Syria to deliver.  
 312 **I2:** Right. So she really believes in this doctor?  
 313 **R:** (in English) Yes, in my doctor.  
 314 **I2:** Why...what do you like about this doctor in your native place, why do you like  
 315 him...so much?  
 316 **R:** (in English) because my parents are having faith that's why.  
 317 **I2:** Yeah.  
 318 **R:** (in English) they trust my brother, and he is having more trust in the doctor.  
 319 **I2:** So did they recommended the doctor to you, they said, "Come here, you have the  
 320 baby here"?  
 321 **R:** (in English) Yes.  
 322 **I:** And...so your brother recommended the doctor to you?  
 323 **R:** Hmmm.  
 324 **I:** You said he is very famous and people come to him from far away, so why is he  
 325 famous? What is the quality that the doctor has which makes him so special?  
 326 **R:** That doctor...the thing is...I mean most of the deliveries there are normal...he  
 327 does only normal deliveries and moreover...(R asks her niece to go sit by the  
 328 window)...  
 329 **I2:** (To I) Ask her (Inaudible 18.48 – 18.52).  
 330 **I:** Tell me. You were telling me that special quality about the doctor.  
 331 **R:** Most of the times they get normal delivered done. And those people who don't  
 332 have any children, if they take treatment there then they have a child in a year to year  
 333 and a half.  
 334 **I:** Is it a fertility clinic?  
 335 **R:** By fertility I mean that they don't do this, that thing also happens in fertility  
 336 clinics when they take the...this from someone to...  
 337 **I:** Sperm donor?  
 338 **R:** ...donor gives, yes it is not that type of a clinic. They give just treatments like  
 339 vaccinations and the tablets and stuff that he gives, [people have children] because of  
 340 these things. And we have some family friends who did not have children for many  
 341 years, they had gone to a lot of doctors and they had tried a lot but they just couldn't  
 342 have a baby. Then we recommended this doctor to them and then she was pregnant  
 343 within a year to year and a half's time, he has many such cases similar to this one.  
 344 **I:** In your family-  
 345 **R:** Yes, they are family friends.  
 346 **I:** No, I meant babies born in your family...are all of those born there at the same  
 347 place or anywhere else too?  
 348 **R:** In my family and at the place of my brother's in-laws, everyone in their family  
 349 goes there. My sister-in-law has 2-3 sisters, one of them is in Washington [town in a

350 western state in India] and one is in Canada [small city near Mumbai]. Even they  
 351 delivered there [at Greenland].

352 **I:** So do you know someone there at that hospital?

353 **R:** No, but later we came to know people there because once everyone started going  
 354 there from the same family...for instance them 3 [sister-in-law and her sisters] and  
 355 then I went too, that made it 4 from the same family. More 5-6 people from our  
 356 family went there for delivery, because of all these things we started to know people  
 357 there.

358 **I:** Do you think knowing someone makes a difference?

359 **R:** No, nothing like that, that doctor...even if someone goes there for the 1<sup>st</sup> time the  
 360 doctor has the same effect on you.

361 **I:** So you say that he [his treatment] is extremely effective?

362 **R:** Yes, you don't need to know someone there.

363 **I:** And what if something like this would have happened...I mean...your father paid  
 364 all the expenses, right?

365 **R:** Hmmm, hmmm.

366 **I:** What if he wouldn't have paid the expenses then where would you have  
 367 conducted the delivery?

368 **R:** (no response).

369 **I:** I am just asking you hypothetically.

370 **R:** No, even then I would have done it there, then my husband would have given me  
 371 the money...my husband would have borne the expenses but the delivery would take  
 372 place only there and nowhere else. And even I were to get pregnant for the second  
 373 time then also the delivery would take place there.

374 **I:** You mean to say again you will go for check-ups to Greenland?

375 **R:** Yes.

376 **I:** And what if your husband would have said that no go to one of these hospitals  
 377 here, then what would you do?

378 **R:** Then there is this EA hospital, where [my sister-in-law] delivered, he would have  
 379 asked me to go there.

380 **I:** Is EA a government hospital?

381 **R:** Yes, it's a charitable hospital, it is a government cum charitable hospital (her  
 382 words).

383 **I:** What if you wouldn't have an option of going to Greenland, what if Mumbai was  
 384 to be the only option, what would you have done then?

385 **R:** Even then he would have asked [me to go to] the same hospital, EA in Venice.

386 **I:** (to I2) She says if the parents wouldn't have incurred the costs, she would have  
 387 asked her husband and-

388 **I2:** And is there no hospital in Mumbai that she could go to?

389 **I:** EA.

390 **R:** EA hospital in Venice.

391 **I2:** That's private?

392 **R:** (in English) Charitable hospital.

393 **I2:** And how do you know about that hospital?

394 **R:** (in English) Because my sister-in-law delivered just now...before 15 days [ago].

395 **I2:** The CO is your sister-in-law?

396 **R:** (in English) No, no, no, no.

397 **I:** This kid's [referring to the child accompanying R].

398 **R:** (in English) She is her mother.

399 **I2:** Oh! Sorry.

400 **I2:** Right, so is it important that somebody recommends a hospital? Is that a good  
 401 thing?  
 402 **R:** Yeah, (switches to Marathi) this aunty, I mean my husband's aunty she had told  
 403 us about the hospital, even she had delivered there in Venice in EA hospital.  
 404 **I:** Okay.  
 405 **R:** (in English) Before...19 years [19 years ago].  
 406 **I2:** So let's say...that...hospital...there is no mummy and daddy [who] said come to  
 407 [this hospital]...let's say...that they charge 30 thousand rupees, 40 thousand rupees.  
 408 Will you still go there? Or you will go to someone here?  
 409 **R:** (in English) No, that doctor doesn't take that much money.  
 410 **I:** Is it important that someone recommend that a particular doctor is good?  
 411 **R:** That's called experience. [Recommendation] is not as important [as experience],  
 412 for instance you have the experience of this [SNEHA] centre, so according to your  
 413 experience [which you tell me about] I will come here.  
 414 **I:** Okay, so then what if I tell you that this particular hospital is good, go there. I  
 415 mean I will assure you that it is good because I know about it through my experience  
 416 and you don't know much about Mumbai so-  
 417 **R:** I will go once and see and once I am assured (her word) then I will go. (Laughs).  
 418 **I:** Okay.  
 419 **I2:** How was your experience with the doctor, you also had good experience or...  
 420 **R:** (in English) Which doctor, that Vidarbha doctor?  
 421 **I2:** Yes.  
 422 **R:** (In English) My situation was normal delivery.  
 423 **I2:** (To I) When she had her delivery there how was it? Was it like she expected it  
 424 [to be]?  
 425 **I:** (to R) Your sister-in-law had gone to that doctor and then you went there, so I am  
 426 assuming that you had some expectations from that doctor of some kind-  
 427 **R:** What do you mean by expectations?  
 428 **I:** You thought that the doctor was so good and when you went for delivery and/or  
 429 check-ups then...were your expectations fulfilled?  
 430 **R:** Yes.  
 431 **I:** So what were your expectations?  
 432 **R:** No, I mean the only [expectation] I had was...that the delivery should have been  
 433 normal and nothing else.  
 434 **I:** Okay, and-  
 435 **R:** When I went there for delivery I was admitted at 11 in the night and he was born  
 436 the next day at 2.30, the delivery was normal. If I would have gone to some other  
 437 doctor then I would have had to get a caesarean done...because during his time  
 438 [when she was pregnant with the baby] the umbilical cord was entangled, that doctor  
 439 even gave treatment (her word) for the umbilical cord. The entire umbilical cord was  
 440 entangled, the doctor- (R's baby starts crying, she tries to pacify him).  
 441 **I:** You knew that the doctor was famous and people used to come to him from far  
 442 away, so when you went there was it true [was his reputation justified]? You said  
 443 that the people in government hospital don't treat patients well, that they don't talk  
 444 properly, did this one talk properly?  
 445 **R:** Yes, the good thing about him is that he gets the fear out of you.  
 446 **I:** Fear about what?  
 447 **R:** I mean one has fear during the first delivery usually...people talk...so because of  
 448 all this there was some fear that I had, [I wondered] how will it [the delivery]  
 449 happen? What will happen during that time? All this he used to take care of, [he used

450 to say], “Don’t be scared dear. There is nothing to be scared of, all this is normal,  
 451 don’t be tensed.” And whatever he said...you felt like... one second-  
 452 (R’s phone rings, she answers it. Many people speaking in the background. R hangs  
 453 up the phone and apologizes, I asks her not to apologize since R is the one giving her  
 454 time to I.)  
 455 **I:** So...if I ask you...you have been to [a] government [hospital] twice or thrice, you  
 456 have experienced private hospitals too, you have told us some of the differences  
 457 between the two but...have you ever felt that a certain kind of people are treated  
 458 differently or they-  
 459 **R:** Yes, this absolutely happens, [patients] who know someone at the hospital get a  
 460 certain kind of treatment. For example consider the case of getting a vaccination, if  
 461 the nurses know someone from the patients then they...what they do normally is  
 462 they [the nurses] distribute numbers [for the queue], they distribute around 40-50  
 463 numbers in a day. The rest of the people start queuing up at 8 in the morning and  
 464 their turn comes at 12 or 1 in the afternoon and those who know someone at the  
 465 hospital go inside without queuing. I saw that this happens, because of this...patients  
 466 who are known to the staff are taken inside before their turn and those patients who  
 467 have been waiting since 8 in the morning go inside at 11 or 12 in the afternoon.  
 468 What happened during her [referring to her niece] mother’s time you see...the first  
 469 time we took [the baby] for the BCG vaccine, we took such a small baby at 8 in the  
 470 morning and we could go inside only at 12 noon. I mean we sat with the baby all that  
 471 time, her mother was caesarean patient so she had stayed back home, we waited with  
 472 the small baby for 4-5 hours...we had to sit around for so long with that small baby.  
 473 **I:** Do you feel that this wouldn’t have happened in a private hospital?  
 474 **R:** In [a] private [hospital] you’ve to wait maximum for half an hour, not more than  
 475 that.  
 476 **I:** Why do you think you’ve to wait so long [in a government hospital]?  
 477 **R:** That’s how they give the numbers, I mean they start giving the numbers at 10 in  
 478 the morning and to collect that number you have to go at 8 in the morning, what I  
 479 mean is that you have to go to at 8 and they don’t even give numbers more than 50.  
 480 **I:** And what if there are more than 50 people?  
 481 **R:** So they go back. They have to go back and come next Tuesday because the  
 482 vaccination is given on Tuesdays and Saturdays. If they cross 50 on say a Tuesday  
 483 then they have to come again on Saturday. That’s what.  
 484 **I:** Has this happened to you?  
 485 **R:** Hmm?  
 486 **I:** Has this happened to you? You-  
 487 **R:** Yes, this has happened with me once, I was late and then they asked me to come  
 488 again on Saturday.  
 489 **I:** Do you feel that there is any other kind of discrimination that takes place in the  
 490 hospital?  
 491 **R:** What do you mean?  
 492 **I:** What I am telling you is...for example...when we talk to women they tell us  
 493 that...if there are women who have more than 2 children...then...they are shouted  
 494 at...have you experienced this happening to someone-  
 495 **R:** This hasn’t happened in front of me...I haven’t seen this.  
 496 **I:** What would you tell me if were to ask you what is a good doctor?  
 497 **R:** The one who has given treatment, if his treatment makes an improvement in one  
 498 dosage [of medicine] or even two then...and he should guide us properly, he should

499 be supportive, this and he should also be good to speak with. If the doctor is all these  
500 things then he is a good doctor.

501 **I:** And during pregnancy who is a good doctor?

502 **R:** I mean he should give the proper treatment, he should tell everything and explain  
503 everything properly.

504 (R's child cries, R tries to calm him down).

505 **I:** Your doctor was a male, right?

506 **R:** Yes.

507 **I:** So do you prefer a male or a female doctor?

508 **R:** Nothing like that, this doctor that I had he was alright as a gent, and there is this  
509 other doctor in Greenland called Dr. Geller, she is a lady but even she is good. When  
510 I was in Canada I had those what do they call them...blood clots...I had those, at  
511 that time I used to work in Canada and had gone to a doctor there...

512 **I:** Was this before you got married?

513 **R:** Yes, before the marriage, at that time the doctor from Canada had asked me to get  
514 an operation done but then I went to Dr. Geller. Even my aunt had the same problem,  
515 she had taken her treatment and she was cured, so that doctor gave me medicines for  
516 continuous 8 months. I continued them for 8 months and because of them I had an  
517 instantly good effect. I had taken them for 8 months. The first time I went to her she  
518 asked me to get a sonography done to see how many centimeters was the clot and  
519 then she asked me to get it done after 8 months. And she did not even have to call  
520 me between those 8 months, she was right in estimating that I would have to take  
521 these medicines for 8 months and then I would go to her after 8 months, get a  
522 sonography done and by then it had become nil (her word). And then she asked me  
523 to make weekly visits.

524 **I:** And did you take any type of alternative medicines like Ayurvedic or Unani?

525 **R:** No, nothing like that. I only took those which the doctor prescribed, that's what,  
526 right?

527 **I:** Then-

528 (I and R talk to R's niece, she has been trying to drink some tea.)

529 **I:** -was there any problem during the pregnancy? I mean you had mentioned that if  
530 you had any problem you used to go to Dr. Geller.

531 **R:** By problem I meant that if there was any problem then I used to go.

532 **I:** What problem?

533 **R:** No, I mean if I couldn't go for 2 months then I used to go there, otherwise I  
534 haven't had any trouble during my pregnancy. Just that if I couldn't go there [home  
535 to the regular doctor] then I used to go here.

536 (R's child cries, R talks to him. Meanwhile I and I2 talk; I2 asks some questions, I  
537 answers them. Simultaneous conversations take place between R and her child and I  
538 and I2.)

539 **I:** Do you want to ask something? I mean we asked you these questions, do you want  
540 to ask anything about them?

541 **R:** No, I mean I want to ask that you asked me all these questions, what are you  
542 doing this research for?

543 **I:** Okay, see...what happens is...it is said that people who have money go to private  
544 hospitals and those who don't have the money go to a government hospital, this kind  
545 of a thing doesn't happen in all countries. Then we collected some data and saw that  
546 even those people who didn't have much money went to private hospitals. So we are  
547 trying to see why is that people who don't have money go to private? Or why don't

548 people go to government hospitals? We want to know all this and importantly how  
 549 do women decide and make a choice about the hospital-  
 550 (R's child and niece get restless, I and R assure them that the interview will be over  
 551 soon.)  
 552 **I:** -for that purpose, for the purpose of research, nothing else. You have given us so  
 553 much information, do you want any information from us? Anything about health  
 554 or...  
 555 **R:** Yes, you are doing this survey, you would have an idea about which doctor is  
 556 [good], you are doing so many surveys, you would have information about which  
 557 doctors are good in this area, you must have done some surveys with doctors too,  
 558 you would know which are the good doctors, which are the private ones and which  
 559 are the government ones. So you can tell us where we could go.  
 560 **I:** Once we are done with all of this all the information that you have asked for...we  
 561 will give it on a pamphlet. So you want to know which doctors are here in this area  
 562 and their contact details and such, right?  
 563 **R:** Yes.  
 564 **I:** Okay. So once all this is done we will send all the information to the centre and  
 565 you can collect it from here. Is there anything else that you want to ask us?  
 566 (I and I2 talk about the interview. I asks I2 if he wants to ask anything, I2 asks I to  
 567 carry on with the interview.)  
 568 **I:** Do you want to ask him anything?  
 569 **R:** No, I just want that thing which I asked for.  
 570 **I:** Okay, that's it? Anything else about the questions that I asked?  
 571 **R:** No.  
 572 **I:** No? Okay. Thank you.  
 573 **I2:** Sorry, I would like to know that like...in this building are there all types of  
 574 people, like richer people, less rich people, you are educated, are there...many types  
 575 of people in this building?  
 576 **R:** (in English) Yeah, high educated, uneducated  
 577 **I2:** Yeah-  
 578 **R:** (in English) Different types, all.  
 579 **I2:** Also income wise? Higher or lower?  
 580 **R:** (in English) Yeah, yeah, yeah.  
 581 (R's child begins crying loudly.)  
 582 **I2:** You were able to...able to travel and go to private clinic to have a baby. What do  
 583 other people do? Does everybody go to private? Or somebody will go to  
 584 government?  
 585 **R:** (in English) No, mostly here...all...they go to private hospital only, small clinics  
 586 only, not a hospital.  
 587 **I2:** For delivery or for check-ups?  
 588 **R:** (in English) For check-ups.  
 589 **I2:** And for delivery where do these people go?  
 590 **R:** (in English) The middle class families they are going to general hospital only,  
 591 otherwise they prefer the EA hospital in Venice.  
 592 **I2:** Is it because it is too expensive? Is it [about] money?  
 593 **R:** (in English) Yes, money, money, money.  
 594 **I2:** You think that if they would have had more money they...the poor would go to  
 595 private?  
 596 **R:** (in English) Yeah, yes, yes. Because all are having two-two three-three children,  
 597 they are not having monthly income that much.

598 **I2:** Yeah.

599 **R:** (in English) They cannot afford more private hospitals.

600 **I2:** Yeah...and from what do they tell you...what do they tell you about having baby

601 in a government hospital? Is it not very good? Is it sometimes okay?

602 **R:** (in English) She [referring to the other woman being interviewed in the room by

603 I's colleague] is having experience because she has having four children in

604 government hospitals, she is my neighbour.

605 **I2:** She? The lady here?

606 **R:** (in English) She is neighbour also, my neighbour.

607 **I2:** Oh, okay. Yeah. But you do not think that you will ever go to government, no?

608 **R:** (in English) No.

609 **I2:** Because I think you said cleanliness was one of the things?

610 **R:** (in English) Yes, cleanliness.

611 **I2:** Was it the main thing or ... or?

612 **R:** (in English) Not only cleanliness [but also] their treatment also not good.

613 **I2:** When you say treatment you mean the-

614 **R:** (in English) Both, both.

615 **I:** Medical and-

616 **I2:** Medical treatment and-

617 **R:** (in English) Medical as well as...

618 **I:** Medical as well as interaction both [are] not good.

619 **I2:** Can you...can you...I have actually never been...really...to a government

620 hospital, so when you say that treatment like the doctors and the nurses...

621 what...what kind of treatment? Can you describe?

622 **R:** (in English) They are not telling us properly, how...what we have to do, what not

623 to do, when we have to come, which vaccination they are giving, which vaccination

624 we have to take from outside.

625 **I2:** Why...why do they do that you think? Why...why do they not tell you all

626 properly? What-

627 **R:** (in English) They...they are waiting (?) they have to treat more people at [in] a

628 single day, that is why they are not properly talking.

629 **I2:** Less time?

630 **R:** Yes, (In English) yes sir.

631 **I2:** It is not because they think that they are better than you?

632 **R:** (in English) No, no, no.

633 **I2:** It's just...the time-

634 **R:** (in English) Because they have to treat so many peoples at a [in] one day, so they

635 also are so frustrated, there are so many different type of people, how we are talking

636 to them, some persons are there, they are understanding their problems, someone do

637 not understand, they have to treat different types of persons.

638 **I2:** Yeah. In private hospital is it different? Do they give better treatment?

639 **R:** (in English) Yeah, I have experience, that is why.

640 **I2:** Right. So what is your experience of the private hospital? How is it different?

641 **R:** (in English) The private hospitals...they take care because we are

642 having...paying money, here government hospital we are not paying the money,

643 because they treat...that is also one reason that they do not properly treat us. In

644 private hospital they treat us properly because we are paying money to them so we

645 should also get satisfaction from them.

646 **I2:** Right, because you are paying money they have to give you the satisfaction?

647 **R:** (in English) Yes.

648 **I2:** And do they have more time? Is it that they more time with you also because you  
649 said-

650 **R:** (in English) They are giving more time here, proper time, not too much but  
651 proper time, what we have to tell, they are giving that much time.

652 **I2:** So they listen to you and you ask questions and they give you answers and  
653 information?

654 **R:** (in English) Yeah, they are giving, I am having experience with two private  
655 doctors, one doctor Dr. Luther and one Dr. Ripley, they both are giving time, they  
656 can understand what we have to tell, what we have to ask, they also telling us what  
657 we have to do, what we do not have to do.

658 **I2:** Yeah.

659 **R:** (in English) That much.

660 **I2:** Do you think...do you think that when they are giving you this service they are  
661 explaining you? Do you think that they are giving that because they want to give  
662 good service or they want to earn money...or...what do you think their motivation is  
663 for working? Because some people say, "In private hospital it is money, money and  
664 money, that is all" but you have good experience...so you think they...they...they  
665 want to give good service or-

666 **R:** (in English) I am choosing very few person and they are giving me satisfaction,  
667 only them I trust, others I will not trust, from them I am getting satisfaction, them  
668 only I trust, otherwise I will not go.

669 **I2:** And satisfaction for you is good treatment you said-

670 **R:** (in English) Yes.

671 **I2:** - and information?

672 **R:** (in English) Yes.

673 **I2:** -and anything else?

674 **R:** (in English) And they should treat with us properly.

675 **I2:** Like speaking to you nicely?

676 **R:** (in English) Speaking and...telling us properly the information and giving  
677 treatment.

678 **I2:** And if they don't, if you are not satisfied have you ever said to the doctor, "I am  
679 not happy" or oops-

680 (R's niece spills the tea. It is cleaned up and interview resumes.)

681 **I2:** -if...if you are not satisfied with a doctor private one...is it possible to  
682 say...ummm...[that] I am not very happy...

683 **R:** (in English) Yes, I have said, I will speak openly.

684 **I2:** You do?

685 **R:** (in English) Yeah. Because I am paying if I am paying him then I have to be  
686 straight, if I am not saying then what is the use of giving money? I am openly saying  
687 to him or to anyone from which I am not getting satisfaction. I told the doctor that I  
688 am not getting satisfaction; I am not satisfied with my...treatment and your  
689 medicine.

690 **I2:** So if you have another baby you will go back to the same [hospital]?

691 **R:** (in English) No, I will not have a second baby.

692 **I2:** Oh, you don't want one.

693 **I:** The way we talked a while ago...*if* you have a baby?

694 **R:** Yes, (in English) if second baby I will have then I will go to that doctor only.

695 **I2:** You are happy with one?

696 **R:** (in English) Oh yeah, sure.

697 **I2:** Because having two three is more expensive? Or one is enough or-



698 **R:** (in English) No, one is enough for me (laughs).  
699 **I2:** (to I) Okay, I think that's alright. Does she have anything to ask us? (to R) Do  
700 you have anything to ask us anything?  
701 **I:** She did.  
702 **I2:** Thank you so much for your time.  
703 **I:** Thank you. You gave us so much of your time. Thank you so much.  
704 **R:** No, nothing like that. Even we got to know a lot of information from you and the  
705 issue is that...here in Argentina...this area no...  
706 **I:** Yes?  
707 **R:** Here...in here...people who stay here are of low quality (her words), they don't  
708 have many facilities...where they can reach...and I am happy that you...[I am glad]  
709 that there are even people like you who come and take information from such  
710 areas...and they do all these investigations (her words). And the people who stay  
711 here have low incomes...they (unclear 46.52) other people (her words)...except  
712 them, except the local people...if you come to ask here then I feel that its alright,  
713 there is some development going on here too. Because of all this I feel good. (In  
714 English) Thank you so much.  
715 **I:** (to R) Thank you. (to I2) She is glad that you asked the questions because she  
716 feels like someone cares about the people in this area.  
717 **I2:** Yeah!

**END OF TRANSCRIPT**

## SUMMARY

The respondent (R) is Hindu woman from the least poor SES with high education – she has a Master’s degree and has delivered in a private facility outside Mumbai at a place near her parents’ home – 12 hours away from Mumbai. She had many reasons for traveling so far for her ANC and delivery; most of these reasons revolve around faith in the provider. She doesn’t trust many doctors in Mumbai; this was not just for her pregnancy but also for regular ailments. She is relatively new to Mumbai and has spent most of her life in towns in Maharashtra and doesn’t know many doctors in big city. Moreover she thinks that the private doctors in Mumbai that she has sought healthcare from have not been good because their medical treatment doesn’t help her and her family to get better.

When she discovered that she was pregnant she accessed ANC for the first 2 months from a private facility in Mumbai, later her mother took her to a doctor near her home because within her community the first delivery takes place at the mother’s home. She used to travel to Greenland, her mother’s home every 2 months for ANC – a distance which could be covered in approximately 12 hours by train. In case she couldn’t travel to her mother’s home she would seek some part of her ANC from a private doctor in Mumbai; this doctor was a woman whereas her regular doctor was a man, she reported no preference for either a female or a male doctor.

The expenses for the pregnancy and delivery were covered by her parents. She trusts the private sector more than the government sector because according to her there is mistreatment in the government sector and there is a long wait to access healthcare, she reports that knowing someone in a government healthcare facility helps one’s cause as the waiting time reduces drastically. Her reasons for choosing the private provider near her mother’s home revolved around her faith in the provider. She had more faith in the provider because he was famous among patients due to his high level of experience and because of his ability to deal with complicated cases. Her faith in the provider is also because of previous utilization by her sister-in-law and her family. Also she reported that the doctor offered her support during her pregnancy and dispelled fears that she had regarding being a primigravida and delivering for the first time.

## Appendix M. Example of an early codebook

Name	Description	Hierarchical Name
accessing private care up to a point	This code is about being able to access the private sector (whether by choice or not wanting to go to a public facility) even if it means you can only afford a certain level of care or services.	Nodes\\accessing private care up to a point
affordability	This code mainly refers to a person's ability to pay for treatment, and how it influences their choice of healthcare provider. It can also include, however, respondents' perceptions and opinions about the relative cost of consultations, medicines etc across sectors and providers.	Nodes\\affordability
attentive staff	Facility staff attend to your needs.	Nodes\\attentive staff
current or previous utilisation experience	Various positive and negative experiences of seeking care in particular health facilities. We might merge some of the data in this code (later on) into the parent node 'Reasons for choosing a health facility'	Nodes\\current or previous utilisation experience
dai does home birth	Information and evidence of how, when and why dais are called - and do home births.	Nodes\\dai does home birth
disrespectful practices in hospital	This node includes a range of behaviours and practices that hospital staff in both public and private sectors have done (or have reportedly done) to clients. For example, tying the legs, leaving them naked etc.	Nodes\\disrespectful practices in hospital
easier to get birth certificate		Nodes\\easier to get birth certificate
expectations	What women expect from a provider or a health facility. Initially, we are interested in knowing whether women expect anything in particular (e.g. efficiency, polite treatment) but it might also affect their choice of provider.	Nodes\\expectations
fear of institutional care	This can include a real or perceived fear of what goes on in a particular facility, for example, a large hospital that deal with complicated cases	Nodes\\fear of institutional care
fear of mistreatment or poor quality	Mistreatment might include being shouted at, having your legs tied during delivery, being left naked in view of others. See also, 'disrespectful practices in hospital'	Nodes\\fear of mistreatment or poor quality
giving food at the time of delivery	The health facility provides food to patients. This might be considered for recoding into 'Reasons for choosing a health facility'?	Nodes\\giving food at the time of delivery
having people to look after me	The decision where to seek care is influenced by the woman's social support system and where there are people to look after her during and after her pregnancy	Nodes\\having people to look after me
higher parity	How having the third or higher delivery affects a person's choice of provider (including fear or actual cost of penalty).	Nodes\\higher parity
husbands don't decide	The husband does not make the decision or even take part in the decision about maternity care seeking. He allows the woman (perhaps with input from others) to decide.	Nodes\\husbands don't decide
'if it pains'	This describes pain as an indicator that care is required. It refers specifically to the time to seek care but might refer to the choice of provider. See also 'seeking care when there is a problem'	Nodes\\'if it pains'

'injections'	This code is about references to 'injections' rather than what we might assume are antenatal check-ups. We can also code other instances of 'injections' to try to understand what women mean when they talk about them	Nodes\\'injections'
institutional delivery outside Mumbai	Cases where a respondent has chosen to deliver outside Mumbai.	Nodes\\institutional delivery outside Mumbai
irrelevant	Anything that we do not code elsewhere because it is not relevant for our study.	Nodes\\irrelevant
it helps to know someone at the hospital	Knowing someone who works in the hospital can be helpful because they can support you, help you sort out problems or get things done etc.	Nodes\\it helps to know someone at the hospital
keeping options open	Care-seeking behaviour that is flexible and open in order for you to take a decision later on, e.g. simultaneously having antenatal care with a public and a private provider.	Nodes\\keeping options open
living in Mumbai	Parent node containing descriptive codes about what aspects of life in Mumbai are like.	Nodes\\living in Mumbai
certain knowledge required	Living (successfully) in Mumbai requires certain knowledge and skills perhaps not necessary in small towns and villages, e.g. navigating the city, including language skills, 'modern' thinking and behaviour.	Nodes\\living in Mumbai\\certain knowledge required
'convenience'	Things in Mumbai are convenient and accessible/nearby (sometimes compared to elsewhere).	Nodes\\living in Mumbai\\'convenience'
everything is available	In Mumbai you can get everything you want. There is no lack of anything.	Nodes\\living in Mumbai\\everything is
'there is work here'	People who come to Mumbai find work. There is work in Mumbai.	Nodes\\living in Mumbai\\'there is work
'you need to have money'	Money is required to avail of the wide range of services and facilities available in Mumbai.	Nodes\\living in Mumbai\\'you need to
'made to run around'	Being made to fetch/provide certain documents, have tests, queue for things, go here and there, and generally have to run around and do whatever the nurse/doctor asks.	Nodes\\'made to run around'
mother will take me	The woman's mother decides which facility her daughter will go to.	Nodes\\mother will take me
mother-in-law's decision	The principal role of the mother-in-law in decisions affecting the health of the respondent and which health care facility she should go to for ANC or delivery.	Nodes\\mother-in-law's decision
multiple care sites	Care-seeking across more than one provider for the same condition/check-up; e.g. a woman who has an antenatal check-up in a Mumbai hospital, then, because she travels to her native place, has another check-up there, then, after returning to Mumbai, has her next one in the original facility.	Nodes\\multiple care sites
nobody to accompany	Not going for ANC or delivery because no-one is at home to accompany the woman to a health facility.	Nodes\\nobody to accompany
not reaching the facility in time	When a woman goes into labour and is not able to reach the health facility in time. This can be due to difficult access to her house, distance to the facility, delayed decisions or poor planning for the delivery.	Nodes\\not reaching the facility in time
nurse or Dr comes home	In some cases a doctor or a nurse visits her to do the delivery or give an injection. This might be a reason motivating home births.	Nodes\\nurse or dr comes home
'peace of mind' in private	In private sector facilities you get more 'peace of mind', in terms of feeling reassured	Nodes\\'peace of mind' in private

perceptions about municipal vs private	Ideas about what a municipal facility is. How to define a municipal hospital.	Nodes\\perceptions about municipal vs private
poor behaviour by staff	examples of when a respondent has experienced poor or rude behaviour from any member of hospital staff	Nodes\\poor behaviour by staff
postnatal care at registration facility after home birth	This code refers to women who choose to return to the delivery health facility for their postnatal care (i.e. the place they had registered at).	Nodes\\postnatal care at registration facility after home birth
preference for lady doctor	Women state that they would prefer the doctor to be a lady.	Nodes\\preference for lady doctor
provider's qualifications	Respondent's knowledge about and influence of what qualifications the provider has.	Nodes\\provider's qualifications
public healthcare is a punishment	Municipal hospitals are so badly perceived that you would send your 'enemies' there.	Nodes\\public healthcare is a punishment
Reasons for choosing a provider	This is a parent node that contains factors and reasons to choose a specific health sectors, level of facility, particular doctor or other health care provider. We can include all types of illness as well as routine antenatal and delivery care because we might want to compare similarities and differences later.	Nodes\\Reasons for choosing a provider
belief in provider	Choosing to seek care with a specific provider because you have belief or faith in his or her ability or capacity to help, cure, treat well.	Nodes\\Reasons for choosing a provider\\belief in provider
'big big machines'	This might, in theory, be positive or negative. The positive might refer to the fact that the facility has access to specialised equipment if needed. It might have a symbolic meaning: good equipment = good hospital. The negative meaning might be that 'big machines' make people fearful of seeking care in that hospital.	Nodes\\Reasons for choosing a provider\\'big big machines'
distance and time	Choice of healthcare provider depends on how far it is from the respondent's home.	Nodes\\Reasons for choosing a
everything is taken care of	A particular health facility or sector looks after all your needs. This might include holistic care or looking after particular needs of a client (e.g. a disability).	Nodes\\Reasons for choosing a provider\\everything is taken care of
'good medicines are there'	Belief in the efficacy of medicines provided at a health facility or by a healthcare provider. Specifically, it acts as a reason to choose a particular healthcare facility or provider.	Nodes\\Reasons for choosing a provider\\'good medicines are there'
'there is some relief'	This code refers to the respondent's belief that visiting a particular healthcare provider will bring physical benefit for a health condition (e.g. ease the pain, feel better). It might mean specifically the capacity of the provider to 'heal' or the use of particular methods and treatments.	Nodes\\Reasons for choosing a provider\\'there is some relief'
'we always go there'	The tendency to always visit the same provider for health problems. See also 'we go there since childhood'.	Nodes\\Reasons for choosing a provider\\'we always go there'
'we go there since childhood'	The tendency to visit the same provider consistently over a considerably number of years.	Nodes\\Reasons for choosing a provider\\'we go there since childhood'
recommendation	Healthcare seeking choices based on the recommendations of others. These might be family members, neighbours, people who work in a health facility, SNEHA staff etc.	Nodes\\recommendation
refuting claims of mistreatment	This code refers to people who (given that complaints against treatment in public facilities are common) defend public healthcare providers' (doctors, nurses, <i>ayas</i> etc) behaviour towards clients.	Nodes\\refuting claims of mistreatment

responsibility for making sure delivery is safe	The responsibility for ensuring that the woman's delivery is done safely and that mother and baby are fine. This might be general information (e.g its importance), specific examples, or people (e.g. mother-in-law's responsibility).	Nodes\\responsibility for making sure delivery is safe
seeking care when there is a problem	This refers to the decision about when care is needed and should be sought. The term 'problem' might or might not be used - also code instances where respondents are specific about which types of problems require care.	Nodes\\seeking care when there is a problem
severity of pain	If the labour pains are severe, the woman feels incapable of travelling to a health facility (see memo)	Nodes\\severity of pain
SNEHA centre	Any references to treatment (or other use of) SNEHA centres	Nodes\\SNEHA centre
'that hospital is good'	Clear references that certain hospitals are 'good' as a reason to seek care there. See also 'reputation'. We might add this to 'Reasons for choosing a health facility'.	Nodes\\'that hospital is good'
'they give you protection'	Staff provide protection or security in the hospital, ensuring that nothing happens to you or your baby (e.g. medical care or preventing baby snatching)	Nodes\\'they give you protection'
'they look after you well'	A component of positive perceptions of care, here we are referring to being well looked after.	Nodes\\'they look after you well'
trust in the provider	A person chooses a particular hospital or doctor because they have trust (for whatever reason).	Nodes\\trust in the provider
turned away from facility	This usually refers to a woman who goes to a hospital because she is having labour pains but is turned away (often because the provider says the delivery due date is not now but might be because a watchman does not allow her to enter). It can also refer to any other instance of being prevented from entering a health facility.	Nodes\\turned away from facility
unavailability of staff	When doctors or nurses (or any other key staff) are not available. This might (or might not) discourage people from seeking care at a particular facility.	Nodes\\unavailability of staff
verbal abuse by providers	A case of any member of staff shouting or swearing at a woman or any other person in the health facility - whether it happened, it's a rumour, or the respondent associates it with a particular sector or facility.	Nodes\\verbal abuse by providers

## Appendix N (i). Example of initial theoretical memo

### Exploring the options

A common activity that women seem to engage in when they're considering seeking maternity care is exploring the various available options: 'exploring the options'?

Exploring the options is about gathering and evaluating different types of information and experiential knowledge (your own and from others) to inform a decision about the most appropriate course of action and to feel reassured that a/the most suitable provider will be chosen (*why is this necessary?*).

Types of exploring:

- Gathering evidence of positive experience and outcome from family
- Reflecting on own personal experience of care
- Visiting a health facility to 'check it out' and find out about fees

One reason why women seek information about health facilities is that they don't always know which services are available, what the potential costs are, or what the competencies of medical staff are like. Doctors with more knowledge and experience are better able to treat complications and reduce the likelihood of referral to another facility (*why is referral undesirable?:* inconvenience, implies additional costs, provider might refer you to a less desirable facility (e.g. from private to municipal hospital)).

## Appendix N (ii). Example more developed theoretical memo

### Purpose selection

*Definitions* (from <http://www.oxforddictionaries.com/definition/english>):

- **Purposive:** ‘Having or done with a purpose’.
- **Selection:** ‘The action or fact of carefully choosing someone or something as being the best or most suitable’.

In its fundamental sense, purposive selection is the process of carefully choosing a health care option or provider among an indeterminate set of alternatives on the basis of suitability or being the best available option according to one's circumstances.

In situations where multiple levels and types of health care provider coexist in a largely unregulated sector and where the quality of services, qualifications, training, competence and practices of practitioners vary considerably and are frequently unpublicised, people are compelled to employ a variety of measures to ensure the selection of a suitable service provider. Purposive selection is a process through which people try to choose an option that suits their circumstances and aspirations.

As a health-seeking behaviour, the aim of purposive selection is twofold: a) to [minimise uncertainty and] protect a person from harm or poor experiences and b) to maximise the chances of a positive experience and health outcome. It may be more or less pronounced depending on whether the person is familiar or unfamiliar with a range of providers. If familiar, purposive selection dictates the continuation with, or move away from a previous provider, a decision informed through the reconstruction of experience. If unfamiliar, the selection process is lengthier, involving the stages of information-gathering, advice-seeking, and consideration of the available evidence before a choice is made. Selection is mediated by the individual and family socio-economic situation and the woman's degree of control over social and economic resources.

In inequitable societies, the purposive selection of a suitable provider becomes paradoxically more important (because the untrained, unregulated or poor quality providers are more likely to be more accessible [distance and cost] to them) and more difficult (because their poor socio-economic situation makes it more difficult to select [afford] properly-qualified, better quality, more expensive providers).

The predictive power of purposive selection is that of women from higher socio-economic groups have a social and economic advantage, enabling them to assert preferences and mobilise resources to choose from a wider range of providers, including those in the private sector. Their advantageous social and economic position means that they are able select better quality providers.

The emphasis of the concept is on how a [health care] provider is selected from a range of alternative choices. It neither attempts to explain the point at which someone decides to seek services nor *whether or not* to have institutional care. Therefore, it excludes the decision to have a home birth. However, the concept seems abstract enough to be applied to other contexts and, therefore, offers an opportunity for further development outside health care-seeking.



Appendix O. Example conceptual diagram – purposive selection

